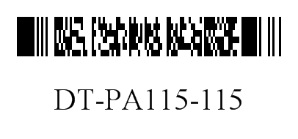
****DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Health Care Access and Accountability Wis. Admin. Code § DHS 107.10(2)

F-01674 (01/2017)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR HIDRADENITIS SUPPURATIVA**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa Completion Instructions, F-01674A. Providers may refer to the Forms page of the ForwardHealth Portal at [*www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage*](http://www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage)for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

|  |  |  |
| --- | --- | --- |
| **SECTION I – MEMBER INFORMATION** | | |
| 1. Name – Member (Last, First, Middle Initial) | | |
| 2. Member Identification Number | 3. Date of Birth – Member | |
| **SECTION II – PRESCRIPTION INFORMATION** | | |
| 4. Drug Name | 5. Drug Strength | |
| 6. Date Prescription Written | 7. Directions for Use | |
| 8. Name – Prescriber | | 9. National Provider Identifier (NPI) – Prescriber |
| 10. Address – Prescriber (Street, City, State, ZIP+4 Code) | | |
| 11. Telephone Number – Prescriber | | |
| **SECTION III – CLINICAL INFORMATION FOR HIDRADENITIS SUPPURATIVA** | | |
| 12. Diagnosis Code and Description | | |
| 13. Does the member have hidradenitis suppurativa?  Yes  No | | |
| 14. Is the prescription written by a dermatologist or through a dermatology consultation?  Yes  No | | |
| 15. Does the member have recurrent abscesses with sinus tracts and scarring?  Yes  No | | |
| 16. Has the member had laser therapy, excision, or deroofing surgery to treat hidradenitis suppurativa?  Yes  No | | |
| 17. Is the member currently using the requested cytokine and CAM antagonist drug?  Yes  No  If yes, indicate the approximate date the therapy was started. | | |

*Continued*

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION** 2 of 3

**MOLECULE (CAM) ANTAGONIST DRUGS FOR HIDRADENITIS SUPPURATIVA**

F-01674 (01/2017)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SECTION III – CLINICAL INFORMATION FOR HIDRADENITIS SUPPURATIVA (Continued)** | | | | |
| 18. Check the boxes next to the drugs below that the member has taken for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction; check “none” if appropriate.  1.  Oral Antibiotics Drug Name       Dose       Dates Taken  Reason for Discontinuation  2.  Oral Retinoids Drug Name       Dose       Dates Taken  Reason for Discontinuation  3.  None  If none, indicate the reason the member is unable to use the drugs listed above.    ***Note:* If none, a copy of the member’s medical records must be submitted with the PA request to support the condition being treated, details regarding previous medication use and outline the member’s current treatment plan.** | | | | |
| 19. Has the member attempted other drug therapies for hidradenitis suppurativa (e.g., topicals or  IV immunomodulators such as infliximab)?  Yes  No  If yes, indicate the drug names, dose, and specific details about the treatment response and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section VI of this form. | | | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | | | |
| 20. **SIGNATURE** – Prescriber | | | 21. Date Signed | |
| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** | | | | |
| 22. National Drug Code (11 Digits) | | 23. Days’ Supply Requested (Up to 365 Days) | | |
| 24. NPI | | | | |
| 25. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.) | | | | |
| 26. Place of Service | | | | |
| 27. Assigned PA Number | | | | |
| 28. Grant Date | 29. Expiration Date | | | 30. Number of Days Approved |

*Continued*

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION** 3 of 3

**MOLECULE (CAM) ANTAGONIST DRUGS FOR HIDRADENITIS SUPPURATIVA**

F-01674 (01/2017)

|  |
| --- |
| **SECTION VI – ADDITIONAL INFORMATION** |
| 31. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here. |