FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE AND ULCERATIVE COLITIS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis Instructions, F-01950A. Providers may refer to the Forms page of the ForwardHealth Portal at 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 Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form signed by the prescriber before submitting a 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 ID 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 – Prescriber

10. Address – Prescriber (Street, City, State, Zip+4 Code)

11. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION FOR CROHN'S DISEASE AND ULCERATIVE COLITIS

12. Diagnosis Code and Description

Note: 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.

13. Does the member have Crohn's disease?	☐ Yes	☐ No
14. Does the member have ulcerative colitis?	☐ Yes	☐ No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	☐ Yes	☐ No

Continued

SECTION III – CLINICAL INFORMATION FOR CROHN'S DISEASE AND ULCERATIVE COLITIS (Continued)

16. Is the member currently using the requested cytokine and CAM antagonist drug? ☐ Yes ☐ No

    If yes, indicate the approximate date therapy was started.

17. Has the member attempted any of the following drugs for Crohn's disease or ulcerative colitis: 6 mercaptopurine (6MP), azathioprine, oral aminosalicylates (balsalazide, mesalamine, olsalazine, sulfasalazine), or methotrexate? ☐ Yes ☐ No

    If yes, indicate the drug name(s), dose, 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 V of this form.

18. Has the member attempted other drugs for Crohn's disease or ulcerative colitis (for example, antibiotics, glucocorticoids, or IV immunomodulators such as infliximab)? ☐ Yes ☐ No

    If yes, indicate the drug name(s), dose, 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 V of this form.

Continued

SECTION III – CLINICAL INFORMATION FOR CROHN'S DISEASE AND ULCERATIVE COLITIS (Continued)

19. Indicate the cytokine and CAM antagonist drugs the member has taken and provide specific details regarding the treatment response. If additional space is needed, continue documentation in Section V of this form.

1. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

2. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

3. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

20. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION IV – AUTHORIZED SIGNATURE

21. **SIGNATURE** – Prescriber	22. Date Signed

SECTION V – ADDITIONAL INFORMATION

23. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

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