DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01950 (01/2021)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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 https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms 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 and dated by the prescriber before submitting a prior authorization 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 A – 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 prior authorization 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

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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.

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 III B – ADDITIONAL CLINICAL INFORMATION FOR XELJANZ XR REQUESTS

21. Prior authorization requests for Xeljanz XR must include detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. This clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz.

SECTION IV – AUTHORIZED SIGNATURE

22. **SIGNATURE** – Prescriber	23. Date Signed

SECTION V – ADDITIONAL INFORMATION

24. 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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