# 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. Prescribers may refer to the Forms page of the ForwardHealth Portal (the Portal) at 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 (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy 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. Address – Prescriber (Street, city, state, ZIP+4 code):

_____

10. Phone number – Prescriber:_____

11. National Provider Identifier – Prescriber:_____

## Section III – Clinical information (Required for all PA requests)

**Note: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.**

12. Diagnosis code and description:

_____

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

16. Is the member currently using the requested non-preferred cytokine and CAM antagonist drug?
❑ Yes ❑ No
If yes, indicate the approximate date therapy was started:_____

17. Indicate the preferred cytokine and CAM antagonist drugs the member has taken, and provide specific details regarding the member's response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form.

a. Drug name:_____ Dose:_____
Dates taken:_____
Description of treatment response and reason(s) for discontinuing:

b. Drug name: _____ Dose:_____
Dates taken:_____
Description of treatment response and reason(s) for discontinuing:

c. Drug name:_____ Dose:_____
Dates taken:_____
Description of treatment response and reason(s) for discontinuing:

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

## Section III A – Additional clinical information for non-preferred adalimumab-xxxx PA requests

19. PA requests for a non-preferred adalimumab-xxxx drug must include detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. This clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

## Section III B – Additional clinical information for Stelara subQ and non-preferred ustekinumab-xxxx subQ PA requests

20. PA requests for Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug must include detailed clinical justification for prescribing Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. This clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

## 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 requested drug may be included here.

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