DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01950 (01/2022)

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. Prescribers 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. 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 A – CLINICAL INFORMATION FOR CROHN'S DISEASE AND ULCERATIVE COLITIS

12. Diagnosis Code and Description

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

13. Does the member have Crohn's disease?	☐ Yes ☐ No
14. Does the member have ulcerative colitis?	☐ Yes ☐ No

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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 member's response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form.

    1. Drug Name _____ Dose _____ Dates Taken _____

       Description of Treatment Response and Reason(s) for Discontinuing

       _____

       _____

    2. Drug Name _____ Dose _____ Dates Taken _____

       Description of Treatment Response and Reason(s) for Discontinuing

       _____

       _____

    3. 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 B – ADDITIONAL CLINICAL INFORMATION FOR XELJANZ XR REQUESTS

19. 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

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

SECTION V – ADDITIONAL INFORMATION

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

Reset Form