DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01951 (01/2018)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR RHEUMATOID ARTHRITIS (RA), JUVENILE IDIOPATHIC ARTHRITIS (JIA), AND PSORIATIC ARTHRITIS

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 Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis Instructions, F-01951A. 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 PA/PDL for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. 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 (NPI) – Prescriber

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

11. Telephone Number – Prescriber

SECTION III – CLINICAL INFORMATION FOR RA, JIA, AND PSORIATIC ARTHRITIS (Required for all requests.)

12. Diagnosis Code and Description

13. Check the box(es) to identify which condition(s) the member has.

1. ❑ JIA
2. ❑ RA
3. ❑ Psoriatic arthritis without axial symptoms
4. ❑ Psoriatic arthritis with axial symptoms

14. Is the prescription written by a rheumatologist or through a rheumatology consultation? ❑ Yes ❑ No

Continued

SECTION III – CLINICAL INFORMATION FOR RA, JIA, AND PSORIATIC ARTHRITIS (Continued)

15. Is the member currently using the requested cytokine and CAM antagonist drug? ❑ Yes ❑ No

    If yes, indicate the approximate date therapy was started.

16. Has the member attempted any of the following drugs for RA, JIA, or psoriatic arthritis: azathioprine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine? ❑ 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 VI of this form.

17. Has the member attempted other drugs for RA, JIA, or psoriatic arthritis (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], 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 VI of this form.

Continued

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS (PA requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.)

18. 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 VI of this form.

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.**

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 _____

19. 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 SIMPONI REQUESTS

20. Will the member continue to take methotrexate in combination with Simponi®? ❑ Yes ❑ No

SECTION IV – AUTHORIZED SIGNATURE

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

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 digits)	24. Days' Supply Requested (Up to 365 Days)

25. NPI

26. 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.)

27. Place of Service

Continued

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SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA (Continued)

28. Assigned PA Number

29.Grant Date	30. Expiration Date	31. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

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

Reset Form