

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION DRUG ATTACHMENT 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 Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis Instructions, F-01951A. 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 RA, JIA, and Psoriatic Arthritis 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.

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**SECTION I – MEMBER INFORMATION**

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1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member

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**SECTION II – PRESCRIPTION INFORMATION**

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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

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**SECTION III – CLINICAL INFORMATION FOR RA, JIA, AND PSORIATIC ARTHRITIS (Required for All Requests)**

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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.**

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DT-PA119-119

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

- 1. ☐ RA
- 2. ☐ JIA
- 3. ☐ Systemic JIA
- 4. ☐ Psoriatic arthritis

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14. Is the prescription written by a rheumatologist, through a rheumatology consultation, by a dermatologist, or through a dermatology consultation?

☐ Yes ☐ No

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15. 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.

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16. 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

\_\_\_\_\_  
\_\_\_\_\_

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

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### SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR SIMPONI REQUESTS

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18. Will the member continue to take methotrexate in combination with Simponi?

☐ Yes ☐ No

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**SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR XELJANZ XR REQUESTS**

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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.

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**SECTION IV – AUTHORIZED SIGNATURE**

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20. **SIGNATURE** – Prescriber

21. Date Signed

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**SECTION V – ADDITIONAL INFORMATION**

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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.
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