DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01951 (05/2023)

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 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 (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 FOR RA, JIA, AND PSORIATIC ARTHRITIS (Required for All Requests)

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.

DT-PA119-119

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

1. ❑ RA
2. ❑ JIA
3. ❑ Systemic JIA
4. ❑ Psoriatic arthritis

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

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.

16. 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.

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

17. 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 ADALIMUMAB-XXXX REQUESTS

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

SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR SIMPONI SUBQ SOLUTION REQUESTS

19. Will the member continue to take methotrexate in combination with Simponi subQ solution? ❑ Yes ❑ No

SECTION III C – ADDITIONAL CLINICAL INFORMATION FOR XELJANZ ORAL SOLUTION OR XELJANZ XR REQUESTS

20. PA requests for Xeljanz Oral Solution or Xeljanz XR must include detailed clinical justification for prescribing these drugs 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 Oral Solution or Xeljanz XR instead of Xeljanz.

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 drug requested may be included here.

Reset Form