DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01952 (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 UVEITIS, GIANT CELL ARTERITIS, AND NEONATAL ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID)

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 Uveitis, Giant Cell Arteritis, and Neonatal Onset Multisystem Inflammatory Disease (NOMID) Instructions, F-01952A. 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 Uveitis, Giant Cell Arteritis, and NOMID form signed by the prescriber before submitting a PA request on the Portal, by fax, or by mail. 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 (Required for all requests.)

12. Diagnosis Code and Description

SECTION III A – CLINICAL INFORMATION FOR HUMIRA® FOR UVEITIS ONLY

13. Does the member have noninfectious uveitis? ❑ Yes ❑ No

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

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

If yes, indicate the approximate date therapy was started.

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SECTION III A – CLINICAL INFORMATION FOR HUMIRA® FOR UVEITIS ONLY (Continued)

16. Check the boxes next to the drugs below that the member has taken for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction; check "none" if appropriate.

1. ❑ glucocorticoid eye drops Drug Name _____ Dose _____ Dates Taken _____

   Reason for Discontinuation _____

2. ❑ oral glucocorticoids Drug Name _____ Dose _____ Dates Taken _____

   Reason for Discontinuation _____

3. ❑ None _____

   If none, indicate the reason the member is unable to use the drugs listed above.

Note: **If none, 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.**

SECTION III B – CLINICAL INFORMATION FOR ACTEMRA® FOR GIANT CELL ARTERITIS ONLY

17. Does the member have giant cell arteritis?	❑ Yes	❑ No
18. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No
19. Is the member currently using Actemra®?	❑ Yes	❑ No

If yes, indicate the approximate date therapy was started.

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.**

SECTION III C – CLINICAL INFORMATION FOR KINERET® FOR NOMID ONLY

20. Does the member have NOMID?	❑ Yes	❑ No
21. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No
22. Is the member currently using Kineret®?	❑ Yes	❑ No

If yes, indicate the approximate date therapy was started.

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.**

SECTION IV – AUTHORIZED SIGNATURE

23. **SIGNATURE** – Prescriber	24.Date Signed

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SECTION VI – ADDITIONAL INFORMATION

25. 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