**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-01952 (01/2019)

**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 GIANT CELL ARTERITIS AND NEONATAL ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID)

**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 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 Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for 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 – Prescriber

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

11. Phone Number – Prescriber

## SECTION III – CLINICAL INFORMATION (Required for all requests.)

12. Diagnosis Code and Description

**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 A – CLINICAL INFORMATION FOR ACTEMRA FOR GIANT CELL ARTERITIS ONLY

13. Does the member have giant cell arteritis? ❑ Yes ❑ No

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

15. Is the member currently using Actemra? ❑ Yes ❑ No

If yes, indicate the approximate date therapy was started.

*Continued*

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## SECTION III B – CLINICAL INFORMATION FOR KINERET FOR NOMID ONLY

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|---|---|---|
| 16. Does the member have NOMID? | ❑ Yes | ❑ No |
| 17. Is the prescription written by a rheumatologist or through a rheumatology consultation? | ❑ Yes | ❑ No |
| 18. Is the member currently using Kineret? | ❑ Yes | ❑ No |

If yes, indicate the approximate date therapy was started.

## SECTION IV – AUTHORIZED SIGNATURE

| 19. **SIGNATURE** – Prescriber | 20. Date Signed |
|---|---|
| | |

## SECTION V – ADDITIONAL INFORMATION

21. 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