FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR GIANT CELL ARTERITIS AND NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA)

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 Non-Radiographic Axial Spondyloarthritis (nr-axSpA) Instructions, F-01952A. Prescribers may refer to the Forms page of the ForwardHealth Portal (the Portal) at 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 Giant Cell Arteritis and nr-axSpA form signed and dated by the prescriber before submitting a 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 (Required for All PA 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.

SECTION III A – CLINICAL INFORMATION 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 the requested non-preferred drug? ❑ Yes ❑ No

    If yes, indicate the approximate date therapy was started.

16. Has the member taken Tyenne subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? ❑ Yes ❑ No

    If yes, list the Tyenne subQ dose and dates taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction. If additional space is needed, continue documentation in Section V of this form.

    Dose: _____ Dates Taken: _____

    Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

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

SECTION III B – CLINICAL INFORMATION FOR NR-AXSPA ONLY

18. Does the member have nr-axSpA? ❑ Yes ❑ No

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

20. Is the member currently using the requested non-preferred drug? ❑ Yes ❑ No

    If yes, indicate the approximate date therapy was started.

21. 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

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

SECTION IV – AUTHORIZED SIGNATURE

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

SECTION V – ADDITIONAL INFORMATION

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

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