DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01952 (04/2021)

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 DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA), GIANT CELL ARTERITIS, NEONATAL ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID), 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 Deficiency of Interleukin-1 Receptor Antagonist (DIRA), Giant Cell Arteritis, Neonatal Onset Multisystem Inflammatory Disease (NOMID), and Non-Radiographic Axial Spondyloarthritis (nr-axSpA) Instructions, F-01952A. Providers may refer to the Forms page of the ForwardHealth Portal at 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 DIRA, Giant Cell Arteritis, NOMID, and nr-axSpA 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, detail previous medication use, and outline the member's current treatment plan.

DT-PA120-120

SECTION III A – CLINICAL INFORMATION FOR KINERET FOR DIRA ONLY

13. Does the member have DIRA?	❑ Yes	❑ No
14. Is the prescription written by or through consultation with a DIRA specialist (for example, an immunologist or a rheumatologist)?	❑ Yes	❑ No
15. Is the member currently using Kineret?	❑ Yes	❑ No

If yes, indicate the approximate date therapy was started.

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

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

If yes, indicate the approximate date therapy was started.

SECTION III C – CLINICAL INFORMATION FOR KINERET FOR NOMID ONLY

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

If yes, indicate the approximate date therapy was started.

SECTION III D – CLINICAL INFORMATION FOR NR-AXSPA ONLY

22. Does the member have nr-axSpA?	❑ Yes	❑ No
23. Is the prescription written by a rheumatologist or through a rheumatology consultation?	❑ Yes	❑ No
24. Is the member currently using the requested non-preferred drug?	❑ Yes	❑ No

If yes, indicate the approximate date therapy was started.

SECTION IV – AUTHORIZED SIGNATURE

25. **SIGNATURE** – Prescriber	26. Date Signed

SECTION V – ADDITIONAL INFORMATION

27. 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