DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02572 (01/2020)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR EUCRISA

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Eucrisa Instructions, F-02572A. Providers 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/Preferred Drug List (PA/PDL) for Eucrisa form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or 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

12. Diagnosis Code and Description

13. Is the member 2 years of age or older? ☐ Yes ☐ No

14. Does the member have atopic dermatitis? ☐ Yes ☐ No

15. Has the member used a topical steroid for at least two consecutive months and experienced an unsatisfactory therapeutic response? ☐ Yes ☐ No

If yes, list the name and strength of the topical steroid, specific details about the unsatisfactory therapeutic response, and the approximate dates that the topical steroid was taken in the space provided.

16. Has the member used a topical steroid and experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

If yes, list the name and strength of the topical steroid, specific details about the significant adverse drug reaction, and the approximate dates that the topical steroid was used in the space provided.

17. Has the member used Elidel or Protopic for at least two consecutive months and experienced an unsatisfactory therapeutic response? ☐ Yes ☐ No

If yes, list the name of the drug used, the strength, specific details about the unsatisfactory therapeutic response, and the approximate dates that Elidel or Protopic was used in the space provided.

18. Has the member used Elidel or Protopic and experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

If yes, list the name of the drug used, the strength, specific details about the significant adverse drug reaction, and the approximate dates that Elidel or Protopic was used in the space provided.

SECTION IV – AUTHORIZED SIGNATURE

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

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 Digits)	22. Days' Supply Requested (Up to 365 Days)

23. National Provider Identifier

24. Date of Service (mm/dd/ccyy) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.)

25. Place of Service

26. Assigned PA Number

27. Grant Date	28. Expiration Date	29. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

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

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