DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02572 (01/2023)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR EUCRISA AND OPZELURA FOR ATOPIC DERMATITIS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Eucrisa and Opzelura for Atopic Dermatitis Instructions, F-02572A. Prescribers 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 PA/PDL for Eucrisa and Opzelura for Atopic Dermatitis form signed and dated 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. 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 (NPI) – Prescriber

SECTION III – CLINICAL INFORMATION

12. Diagnosis Code and Description

13. Does the member have atopic dermatitis? ❑ Yes ❑ No

14. 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 used in the space provided.

15. 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 clinically significant adverse drug reaction, and the approximate dates that the topical steroid was used in the space provided.

16. Has the member used a topical calcineurin inhibitor for at least two consecutive months and experienced an unsatisfactory therapeutic response? ❑ Yes ❑ No

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

17. Has the member used a topical calcineurin inhibitor and experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

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

SECTION IV – AUTHORIZED SIGNATURE

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

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

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

22. NPI

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

24. Place of Service

25. Assigned PA Number

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

SECTION VI – ADDITIONAL INFORMATION

29. 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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