**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-02668 (07/2020)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)   
FOR HEADACHE AGENTS, TRIPTANS NON-INJECTABLE**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Headache Agents, Triptans Non-Injectable Instructions, F-02668A. Providers may refer to the Forms page of the ForwardHealth Portal at [https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/  
ForwardHealthCommunications.aspx?panel=Forms](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 Headache Agents, Triptans Non-Injectable 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.

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| **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. Refills | | |
| 8. Directions for Use | | | | | |
| 9. Name – Prescriber | | | 10. National Provider Identifier – Prescriber | | |
| 11. Address – Prescriber (Street, City, State, Zip+4 Code) | | | | | |
| 12. Phone Number – Prescriber | | | | | |
| **SECTION III — CLINICAL INFORMATION** | | | | | |
| 13. Diagnosis Code and Description | | | | | |
| 14. Has the member experienced an unsatisfactory therapeutic response or a clinically  significant adverse drug reaction with **at least** **three** preferred drugs from the headache  agents, triptans non-injectable drug class?  Yes  No  If yes, list the drug name and date(s) the drug was taken in the space provided for **each** of the **three** preferred drugs the member has taken from the headache agents, triptans non-injectable drug class.  Drug Name       Date(s) Taken  Drug Name       Date(s) Taken  Drug Name       Date(s) Taken  Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s). | | | | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | | | | |
| 15. **SIGNATURE** – Prescriber | | | | | 16. Date Signed |
| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** | | | | | |
| 17. National Drug Code (11 Digits) | | 18. Days’ Supply Requested (Up to 365 Days) | | | |
| 19. National Provider Identifier | | | | | |
| 20. 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.) | | | | | |
| 21. Place of Service | | | | | |
| 22. Assigned PA Number | | | | | |
| 23. Grant Date | 24. Expiration Date | | | 25. Number of Days Approved | |
| **SECTION VI – ADDITIONAL INFORMATION** | | | | | |
| 26. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here. | | | | | |