**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 [ ]  NoIf 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.      |