**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-03175 (07/2023)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT**

**FOR MULTIPLE SCLEROSIS (MS) AGENTS, INTERFERONS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Multiple Sclerosis (MS) Agents, Interferons Instructions, F-03175A. Prescribers 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 Drug Attachment for Multiple Sclerosis (MS) Agents, Interferons form signed and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy 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. Address – Prescriber (Street, City, State, Zip+4 Code)      |
| 11. Phone Number – Prescriber      | 12. National Provider Identifier – Prescriber      |
| **SECTION III – CLINICAL INFORMATION** |
| 13. Diagnosis Code and Description      |
| **Note: Supporting clinical information and a copy of the member’s current medical records must be submitted with all PA requests.**  |

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| 14. Is the member currently using the requested non-preferred MS agents, interferon? [ ]  Yes [ ]  No If yes, indicate the approximate date the therapy was started.      |
| 15. Indicate the preferred MS agents, interferon(s) the member has taken, and provide specific details regarding the member’s response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form.Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuation      Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuation     Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuation       |
| 16. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred MS agents, interferon.      |
| **SECTION IV – AUTHORIZED SIGNATURE** |
| 17. **SIGNATURE** – Prescriber | 18. Date Signed |

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| **SECTION V – ADDITIONAL INFORMATION** |
| 19. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.      |