DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03175 (07/2023)

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

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 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.

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.

DT-PA132-132

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

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.

Reset Form