DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03224 (10/2023)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR UVEITIS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis Instructions, F-03224A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis 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. Directions for Use

8. Name – Prescriber

9. Address – Prescriber (Street, City, State, Zip+4 Code)

10. Phone Number – Prescriber	11. National Provider Identifier – Prescriber

SECTION III – CLINICAL INFORMATION FOR UVEITIS (Required for All Requests)

12. 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.

13. Does the member have uveitis?	❑ Yes	❑ No
14. Is the prescription written by an ophthalmologist or through an ophthalmology consultation?	❑ Yes	❑ No

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15. Is the member currently using the requested non-preferred cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, indicate the approximate date therapy was started.

16. Has the member taken Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, list the Humira dose and the dates taken, and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction. If additional space is needed, continue documentation in Section V of this form.

Dose _____ Dates Taken _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

17. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR ADALIMUMAB-XXXX REQUESTS

18. PA requests for adalimumab-xxxx must include detailed clinical justification for prescribing adalimumab-xxxx instead of Humira. This clinical information must document why the member cannot use Humira, including why it is medically necessary that the member receive adalimumab-xxxx instead of Humira.

SECTION IV – AUTHORIZED SIGNATURE

19. **SIGNATURE** – Prescriber	20. Date Signed

SECTION V – ADDITIONAL INFORMATION

21. 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