**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-03370 (05/2025)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR JOURNAVX**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Journavx Instructions, F‑03370A. Prescribers may refer to the Forms page of the ForwardHealth Portal (the Portal) at [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 PA/PDL for Journavxform signed and dated 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. 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. Directions for Use      |
| 8. Refills      |
| 9. Name – Prescriber      |
| 10. Address – Prescriber (Street, City, State, Zip+4 Code)      |
| 11. Phone Number – Prescriber      | 12. National Provider Identifier (NPI) – Prescriber      |
| **SECTION III – CLINICAL INFORMATION** |
| 13. Diagnosis Code and Description      |
| 14. Does the member have moderate to severe acute pain? [ ]  Yes [ ]  No |

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| 15. Has the prescriber determined that treatment with acetaminophen is not appropriate for the member? [ ]  Yes [ ]  No |
| 16. Has the prescriber determined that treatment with a non-steroidal anti-inflammatory drug is not appropriate for the member? [ ]  Yes [ ]  No |
| **SECTION IV – AUTHORIZED SIGNATURE** |
| 17. **SIGNATURE** – Prescribing Provider | 18. Date Signed |
| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** |
| 19. National Drug Code (11 Digits)      | 20. Days’ Supply Requested (Up to 14 Days)      |
| 21. NPI      |
| 22. Date of Service (DOS) (mm/dd/ccyy) (For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.)      |
| 23. Place of Service      |
| 24. Assigned PA Number      |
| 25. Grant Date      | 26. Expiration Date      | 27. Number of Days Approved      |
| **SECTION VI – ADDITIONAL INFORMATION** |
| 28. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.       |