FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions, F-11075A. Providers 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/Preferred Drug List (PA/PDL) Exemption Request 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.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification 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. National Provider Identifier (NPI) — Prescriber

10. Address — Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

12. Diagnosis Code and Description

13. List the PDL drug class to which the requested non-preferred drug belongs (e.g., COPD agents).

Note: If applicable, prescribers may also complete Section IV of this form if the non-preferred drug belongs to one of the following drug classes: Alzheimer's Agents; Anticonvulsants; Antidepressants, Other; Antidepressants, SSRI; Antiparkinson's Agents; Antipsychotics; HIV-AIDS; or Pulmonary Arterial Hypertension.

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the preferred drugs from the same PDL drug class as the drug being requested? ❑ Yes ❑ No

If yes, list the preferred drug(s) used. _____

List the dates the preferred drug(s) was taken. _____

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

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. Is there a clinically significant drug interaction between another drug the member is taking and at least one of the preferred drugs from the same PDL drug class as the drug being requested? ❑ Yes ❑ No

    If yes, list the drug(s) and interaction(s) in the space provided.

16. Does the member have a medical condition(s) that prevents the use of at least one of the preferred drugs from the same PDL drug class as the drug being requested? ❑ Yes ❑ No

    If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred drug(s) in the space provided.

SECTION IV — ALTERNATE CLINICAL INFORMATION FOR ELIGIBLE DRUG CLASSES ONLY (If applicable, prescribers may also complete this section.)

17. Indicate the drug class.

- ❑ Alzheimer's Agents
- ❑ Anticonvulsants
- ❑ Antidepressants, Other
- ❑ Antidepressants, SSRI
- ❑ Antiparkinson's Agents
- ❑ Antipsychotics
- ❑ HIV-AIDS
- ❑ Pulmonary Arterial Hypertension

18. Is the member new to ForwardHealth (i.e., has this member been granted eligibility for ForwardHealth within the past month)? ❑ Yes ❑ No

    If yes, indicate the month and year the member became eligible in the space provided. ___ ___ / ___ ___ ___ ___ (Month / Year)

19. Has the member taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response? ❑ Yes ❑ No

    If yes, indicate the month and year the member began taking the drug in the space provided. ___ ___ / ___ ___ ___ ___ (Month / Year)

20. Was the member recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested? ❑ Yes ❑ No

    If yes, indicate the facility and month and year of discharge in the space provided.

    Facility Name _____ ___ ___ / ___ ___ ___ ___ (Month / Year)

21. **SIGNATURE** — Prescriber	22. Date Signed

Continued

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 365 Days)

25. NPI

26. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

27. Place of Service

28. Assigned PA Number

29. Grant Date	30. Expiration Date	31. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

32. 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