FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) CAPSULES AND TABLETS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets Completion Instructions, F-11078A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets 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 or on paper. 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. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response to omeprazole? ❑ Yes ❑ No

If yes, list the approximate dates omeprazole was taken in the space provided.

15. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with omeprazole? ❑ Yes ❑ No

If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates omeprazole was taken in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

16. Has the member experienced an unsatisfactory therapeutic response to pantoprazole? ❑ Yes ❑ No

    If yes, list the approximate dates pantoprazole was taken in the space provided.

17. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with pantoprazole? ❑ Yes ❑ No

    If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates pantoprazole was taken in the space provided.

18. Has the member experienced an unsatisfactory therapeutic response to rabeprazole? ❑ Yes ❑ No

    If yes, list the approximate dates rabeprazole was taken in the space provided.

19. Has the member experienced a clinically significant adverse drug reaction(s) to or drug interaction(s) with rabeprazole? ❑ Yes ❑ No

    If yes, list the specific details about the clinically significant adverse drug reaction(s) and/or drug interaction(s) and the approximate dates rabeprazole was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

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

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

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

24. NPI

25. 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.)

26. Place of Service

27. Assigned PA Number

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

SECTION VI — ADDITIONAL INFORMATION

31. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

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