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 (Required for all PA requests.)

13. Diagnosis Code and Description

Continued

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

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** preferred PPI capsules or tablets? ❑ Yes ❑ No

If yes, list the drug name, dosage form, and dates the drug was taken in the space provided for **at least two** preferred PPI capsules or tablets the member has taken.

Drug Name _____ Dosage Form _____ Dates Taken _____

Drug Name _____ Dosage Form _____ Dates Taken _____

Drug Name Dosage Form Dates Taken

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

SECTION IV — AUTHORIZED SIGNATURE

15. **SIGNATURE** — Prescriber	16. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

17. National Drug Code (11 Digits)	18. Days' Supply Requested (Up to 365 Days)

19. NPI

20. 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.)

21. Place of Service

22. Assigned PA Number

23. Grant Date	24. Expiration Date	25. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

26. 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.

Reset Form