DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11083 (07/12)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code
DHS 152.06(3)(h), DHS 153.06(3)(g), DHS 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / BRAND MEDICALLY NECESSARY ATTACHMENT (PA/BMNA)

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA) Completion Instructions, F-11083A.

Prescribers are required to submit this completed form to the dispensing provider where the prescription will be filled.

Pharmacy providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Strength(s)
6. National Drug Code (NDC)	7. Date Prescription Written
8. Directions for Use	9. Start Date Requested
10. Name — Prescriber	11. National Provider Identifier
12. Address — Prescriber (Street, City, State, ZIP+4 Code)	
13. Telephone Number — Prescriber	

14. Is "Brand Medically Necessary" handwritten by the prescriber on the prescription? ❑ Yes ❑ No

SECTION III — CLINICAL INFORMATION

15. Diagnosis — Primary Code and / or Description

16. Has the member experienced a clinically significant adverse reaction to the generic equivalent drug? ❑ Yes ❑ No

If yes, indicate the adverse reaction that can be directly attributed to the generic equivalent drug and the dose and approximate dates the drug was taken.

17. Has the member experienced a treatment failure with the generic equivalent drug? ❑ Yes ❑ No

If yes, indicate the treatment failure that can be directly attributed to the generic equivalent drug and the dose and approximate dates the drug was taken.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

18. Has the member experienced an allergic reaction to the generic equivalent drug? ❑ Yes ❑ No

    Do you anticipate that the brand name drug will not cause the same allergic reaction? ❑ Yes ❑ No

    If yes, indicate the allergic reaction that can be directly attributed to the generic equivalent drug and the dose and approximate dates the drug was taken, if known.

19. Explain how the brand medically necessary drug will prevent the recurrence of the adverse reaction, treatment failure, or allergic reaction described in Elements 16, 17, and 18.

20. Does the member have a medical condition that causes a contraindication to the use of the generic equivalent drug? ❑ Yes ❑ No

    If yes, indicate the medical condition and why or how the condition impacts the use of the generic equivalent drug.

SECTION IIIB — CLINICAL INFORMATION FOR NARROW THERAPEUTIC INDEX DRUGS

21. For the Following Drugs Only: Any Brand Name Anticonvulsant Drug Used to Treat a Seizure Disorder, Clozaril, Coumadin, Neoral, or Prograf

    Does the member's past medical history suggest an anticipated treatment failure of the generic equivalent drug? ❑ Yes ❑ No

    If yes, indicate the prescriber's documentation of the anticipated therapeutic failure* and the past medical history that forms the basis of the anticipated therapeutic failure.

*Therapeutic failure applies to treatment for seizure disorders.

22. **SIGNATURE** — Prescriber	23. Date Signed

SECTION IV — ADDITIONAL INFORMATION

24. Additional diagnostic and clinical information explaining the need for the drug required may be included below.

Reset Form