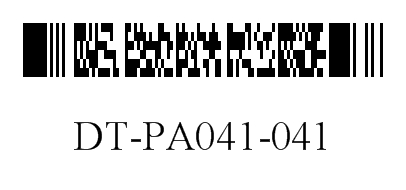
**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-11097 (09/2019)

**FORWARDHEALTH**

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

**FOR STIMULANTS AND RELATED AGENTS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, F-11097A. Providers may refer to the Forms page of the ForwardHealth Portal at [*https://www.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 Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents 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.

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| **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 FOR STIMULANTS AND RELATED AGENTS** **(Providers are required to complete Section III and either Section IIIA or Section IIIB.)** | |
| 12. Diagnosis Code and Description | |
| **SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS REQUESTS (Excluding Kapvay.)** | |
| 13. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically  significant adverse drug reaction with at least **two** preferred stimulants?  Yes  No  If yes, list the preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.  1.  2.  3.  4. | |

*Continued***PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS** Page 2 of 2

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| **SECTION IIIB — CLINICAL INFORMATION FOR KAPVAY REQUESTS ONLY** | | | |
| 14. Will the member take Kapvay in combination with a preferred stimulant?  Yes  No  If yes, list the preferred stimulant in the space provided. | | | |
| 15. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically  significant adverse drug reaction with a preferred stimulant?  Yes  No  If yes, list the preferred stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred stimulant was taken in the space provided. | | | |
| 16. Does the member have a medical condition(s) preventing the use of a preferred stimulant?  Yes  No  If yes, list the medical condition(s) that prevents the use of a preferred stimulant in the space provided. | | | |
| 17. Is there a clinically significant drug interaction between another medication the member  is taking and a preferred stimulant?  Yes  No  If yes, list the medication(s) and interaction(s) in the space provided. | | | |
| **SECTION IV — AUTHORIZED SIGNATURE** | | | |
| 18. **SIGNATURE** — Prescriber | | 19. Date Signed | |
| **SECTION V** — **FOR PHARMACY PROVIDERS USING STAT-PA** | | | |
| 20. National Drug Code (11 Digits) | | 21. Days’ Supply Requested (Up to 365 Days) | |
| 22. NPI | | | |
| 23. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.) | | | |
| 24. Place of Service | | | |
| 25. Assigned PA Number | | | |
| 26. Grant Date | 27. Expiration Date | | 28. Number of Days Approved |
| **SECTION VI — ADDITIONAL INFORMATION** | | | |
| 29. 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. | | | |