FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Completion Instructions, F-11304A. 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 Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis 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. 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 ANKYLOSING SPONDYLITIS

12. Diagnosis Code and Description

13. Does the member have ankylosing spondylitis?	☐ Yes	☐ No
14. Is the prescription written by a rheumatologist or through a rheumatology consultation?	☐ Yes	☐ No
15. Does the member have axial symptoms of ankylosing spondylitis?	☐ Yes	☐ No

Continued

SECTION III – CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS (Continued)

16. Is the member currently using the requested cytokine and CAM antagonist drug? ❑ Yes ❑ No

    If yes, indicate the approximate date therapy was started.

17. Check the boxes next to the drugs below that the member has taken for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction; check "none" if appropriate.

    1. ❑ leflunomide Dose _____ Dates Taken _____

       Reason for Discontinuation _____

    2. ❑ methotrexate Dose _____ Dates Taken _____

       Reason for Discontinuation _____

    3. ❑ NSAID or COX-2 Dose _____ Dates Taken _____

       Reason for Discontinuation _____

    4. ❑ sulfasalazine Dose _____ Dates Taken _____

       Reason for Discontinuation _____

    5. ❑ None _____

       If none, indicate the reason the member is unable to use the drugs listed above.

    Note: **If none, a copy of the member's medical records must be submitted with the PA request to support the condition being treated, details regarding previous medication use and outline the member's current treatment plan.**

18. Has the member attempted other drug therapies for ankylosing spondylitis (e.g., glucocorticoids or IV immunomodulators such as infliximab)? ❑ Yes ❑ No

    If yes, indicate the drug names, dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section VI of this form.

Continued

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS (Prior authorization requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.)

19. Indicate the cytokine and CAM antagonist drugs the member has taken and provide specific details regarding the treatment response. If additional space is needed, continue documentation in Section VI of this form.

Note: **A copy of the member's medical records must be submitted with the PA request to support the condition being treated, details regarding previous medication use, and outline the member's current treatment plan.**

1. Drug Name _____ Dose _____ Dates Taken _____

   Reason for Discontinuation _____

2. Drug Name _____ Dose _____ Dates Taken _____

   Reason for Discontinuation _____

3. Drug Name _____ Dose _____ Dates Taken _____

   Reason for Discontinuation _____

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 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 product requested may be included here.

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