FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN'S DISEASE

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 Crohn's Disease Completion Instructions, F-11305A. 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 Crohn's Disease 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 CROHN'S DISEASE

12. Diagnosis Code and Description

13. Does the member have a diagnosis of Crohn's disease?	❑	Yes	❑	No
14. Does the member have moderate to severe symptoms of Crohn's disease?	❑	Yes	❑	No
15. Is the prescription written by a gastroenterologist or through a gastroenterology consultation?	❑	Yes	❑	No

Continued

DT-PA073-073

SECTION III — CLINICAL INFORMATION FOR CROHN'S DISEASE (Continued)

16. Has the member received **two** or more of the drugs listed below and taken each drug for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, check the boxes next to the drugs the member received. Indicate the dose of the drugs, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space provided.

1. ❑ 5-aminosalicylic (5-ASA) _____
2. ❑ 6-mercaptopurine (6MP) _____
3. ❑ azathioprine _____
4. ❑ methotrexate _____
5. ❑ oral corticosteroids _____
6. ❑ sulfasalazine _____

SECTION IV — AUTHORIZED SIGNATURE

17. **SIGNATURE** — Prescriber	18. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

19. National Drug Code (11 digits)	20. Days' Supply Requested (Up to 365 Days)

21. NPI

22. 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.

23. Place of Service

24. Assigned PA Number

25. Grant Date	26. Expiration Date	27. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

28. 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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