

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIASIS**

**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 Psoriasis Completion Instructions, F-11306A. Providers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage](http://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 Psoriasis form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

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**SECTION I – MEMBER INFORMATION**

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1. Name – Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth – Member

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**SECTION II – PRESCRIPTION INFORMATION**

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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

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**SECTION III – CLINICAL INFORMATION FOR PSORIASIS**

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12. Diagnosis Code and Description

13. Does the member have psoriasis?

Yes  No

If yes, indicate the areas affected and the approximate percent of body surface area involved.

14. Is the prescription written by a dermatologist or through a dermatology consultation?

Yes  No

*Continued*



DT-PA074-074

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**SECTION III – CLINICAL INFORMATION FOR PSORIASIS (Continued)**

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

If yes, indicate the approximate date therapy was started.

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16. Check the boxes next to the treatments 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.  cyclosporine Dose \_\_\_\_\_ Dates Taken \_\_\_\_\_

Reason for Discontinuation \_\_\_\_\_

2.  methotrexate Dose \_\_\_\_\_ Dates Taken \_\_\_\_\_

Reason for Discontinuation \_\_\_\_\_

3.  Phototherapy Dates Tried \_\_\_\_\_

Reason for Discontinuation \_\_\_\_\_

4.  Soriatane Dose \_\_\_\_\_ Dates Taken \_\_\_\_\_

Reason for Discontinuation \_\_\_\_\_

5.  None \_\_\_\_\_

If none, indicate the reason the member is unable to use the treatments 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 treatment use and outline the member's current treatment plan.**

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17. Has the member attempted other drug therapies for psoriasis (e.g., topicals, glucocorticoids, or IV immunomodulators such as infliximab)?  Yes  No

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

**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.)**

18. Indicate the cytokine and CAM antagonist drug(s) the member has taken and provide specific details regarding the treatment response. If more 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**

19. SIGNATURE – Prescriber

20. Date Signed

**SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA**

21. National Drug Code (11 digits)

22. Days' Supply Requested (Up to 365 Days)

23. NPI

24. 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.)

25. Place of Service

26. Assigned PA Number

27. Grant Date

28. Expiration Date

29. Number of Days Approved

**SECTION VI – ADDITIONAL INFORMATION**

30. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.