FORWARDHEALTH

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

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 Psoriatic Arthritis Completion Instructions, F-11307A. 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 Psoriatic Arthritis 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 PSORIATIC ARTHRITIS

12. Diagnosis Code and Description

13. Does the member have a diagnosis of psoriatic arthritis?	❑ Yes	❑ No
14. Does the member have moderate to severe symptoms of psoriatic arthritis?	❑ Yes	❑ No
15. Is the prescription written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation?	❑ Yes	❑ No
16. Does the member have moderate to severe axial symptoms of psoriatic arthritis?	❑ Yes	❑ No

Continued

DT-PA075-075

SECTION III — CLINICAL INFORMATION FOR PSORIATIC ARTHRITIS (Continued)

17. 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 response or clinically significant adverse drug reactions, and the approximate dates the drugs were taken in the space below.

1. ❑ azathioprine _____
2. ❑ cyclosporine _____
3. ❑ hydroxychloroquine _____
4. ❑ leflunomide _____
5. ❑ methotrexate _____
6. ❑ NSAID or COX-2 _____
7. ❑ oral corticosteroids _____

SECTION IIIA — 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. Has the member taken **two** preferred cytokine and CAM antagonist drugs for at least **three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the two preferred cytokine and CAM antagonist drugs and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates each preferred cytokine and CAM antagonist drug was taken in the space provided.

1. _____

2. _____

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.

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