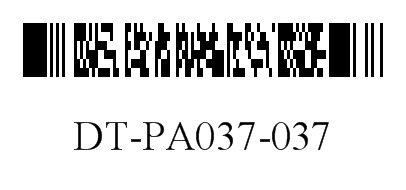
**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**



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

F-11075 (07/2023)

**FORWARDHEALTH**

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

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Instructions, F-11075A. Prescribers 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) Exemption Request form signed and dated by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Prescribers and pharmacy 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 ID 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. Address – Prescriber (Street, City, State, Zip+4 Code) | | | | | |
| 10. Phone Number – Prescriber | | 11. National Provider Identifier (NPI) – Prescriber | | | |
| **SECTION III – CLINICAL INFORMATION (Required for All PA Requests)** | | | | | |
| 12. Diagnosis Code and Description | | | | | |
| 13. List the PDL drug class from the Preferred Drug List Quick Reference to which the requested non-preferred drug belongs (for example, COPD agents). | | | | | |
| **Note:**If applicable, prescribers may also complete Section IV of this form if the non-preferred drug belongs to one of the following drug classes: Alzheimer’s agents; anticonvulsants; antidepressants, other; antidepressants, SSRI; antiparkinson’s agents; antipsychotics; HIV/AIDS; or pulmonary arterial hypertension. | | | | | |
| 14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least one** of the preferred drugs from the  same PDL drug class as the drug being requested?  Yes  No  If yes, list the preferred drug(s) used.  List the dates the preferred drug(s) was taken.  Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s). | | | | | |
| 15. Is there a clinically significant drug interaction between another drug the member is  taking and **at least one** of the preferred drugs from the same PDL drug class as the  drug being requested?  Yes  No  If yes, list the drug(s) and interaction(s). | | | | | |
| 16. Does the member have a medical condition(s) that prevents the use of **at least one** of  the preferred drugs from the same PDL drug class as the drug being requested?  Yes  No  If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred drug(s). | | | | | |
| **SECTION IV – ALTERNATE CLINICAL INFORMATION FOR ELIGIBLE DRUG CLASSES ONLY (If applicable, prescribers may also complete this section.)** | | | | | |
| 17. Indicate the drug class.  Alzheimer’s Agents  Anticonvulsants  Antidepressants, Other  Antidepressants, SSRI  Antiparkinson’s Agents  Antipsychotics  HIV/AIDS  Pulmonary Arterial Hypertension | | | | | |
| 18. Is the member new to ForwardHealth (that is, has this member been granted eligibility  for ForwardHealth within the past month)?  Yes  No  If yes, indicate the month and year the member became eligible.       /  Month Year | | | | | |
| 19. Has the member taken the requested non-preferred drug continuously for  the last 30 days or longer and had a measurable therapeutic response?  Yes  No  If yes, indicate the month and year the member began taking the drug.       /  Month Year | | | | | |
| 20. Was the member recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested?  Yes  No  If yes, indicate the facility and the month and year of the discharge.  Facility Name             /  Month Year | | | | | |
| **SECTION V – AUTHORIZED SIGNATURE** | | | | | |
| 21. **SIGNATURE** – Prescriber | | | | 22. Date Signed | |
| **SECTION VI – FOR PHARMACY PROVIDERS USING STAT-PA** | | | | | |
| 23. National Drug Code (11 Digits) | | | 24. Days’ Supply Requested (Up to 365 Days) | | |
| 25. NPI | | | | | |
| 26. Date of Service (DOS) (mm/dd/ccyy) (For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.) | | | | | |
| 27. Place of Service | | | | | |
| 28. Assigned PA Number | | | | | |
| 29. Grant Date | 30. Expiration Date | | | | 31. Number of Days Approved |
| **SECTION VII – ADDITIONAL INFORMATION** | | | | | |
| 32. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here. | | | | | |