**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 clinicallysignificant adverse drug reaction with **at least one** of the preferred drugs from the same PDL drug class as the drug being requested? [ ]  Yes [ ]  NoIf 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 [ ]  NoIf 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 [ ]  NoIf 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 [ ]  NoIf 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 [ ]  NoIf 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 wasstabilized on the non-preferred drug being requested? [ ]  Yes [ ]  NoIf 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.      |