DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11075 (07/2023)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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 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.

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.

DT-PA037-037

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.

Reset Form