Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitors (PPIs)

Instructions

Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitors (PPIs) Instructions, F-11078A. Prescribers may refer to the Forms page of the ForwardHealth Portal (the Portal) at forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx? panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed PA/PDL for PPIs form signed and dated 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. 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. Refills:_____

8. Directions for use:_____

9. Name – Prescriber:_____

10. Address – Prescriber (Street, city, state, ZIP+4 code):

_____

11. Phone number – Prescriber:_____

12. National Provider Identifier (NPI) – Prescriber:_____

Section III – Clinical information (Required for all PA requests)

13. Diagnosis code and description:

_____

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** preferred PPIs?

❑ Yes ❑ No

If yes, list the drug name and date(s) the drug was taken in the space provided for **at least two** preferred PPIs.

Drug name:_____ Dates taken:_____

Drug name:_____ Dates taken:_____

Drug name:_____ Dates taken:_____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s):

15. Does the member have a medical condition(s) that prevents the use of the preferred PPIs?

❑ Yes ❑ No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using the preferred PPIs.

Section IV – Authorized signature

16. Signature – Prescriber:_____

17. Date signed:_____

Section V – For pharmacy providers using STAT-PA

18. National Drug Code (11 digits):_____ 19. Days' supply requested (Up to 365 days): _____

20. NPI:_____

21. 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.):_____

22. Place of service:_____ 23. Assigned PA number:_____

24. Grant date:_____ 25. Expiration date:_____ 26. Number of days approved:_____

Section VI – Additional information

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

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