

FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR ANKYLOSING SPONDYLITIS

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 Ankylosing Spondylitis Instructions, F-11304A. 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 PA/PDL for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis 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 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. National Provider Identifier (NPI) – Prescriber

10. Address – Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number – Prescriber

SECTION III – CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

12. Diagnosis Code and Description

13. Does the member have ankylosing spondylitis?

Yes No

14. Is the prescription written by a rheumatologist or through a rheumatology consultation?

Yes No

15. Does the member have axial symptoms of ankylosing spondylitis?

Yes No

Continued



DT-PA072-072

SECTION III – CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS (Continued)

16. Is the member currently using the requested cytokine and CAM antagonist drug? Yes No

If yes, indicate the approximate date therapy was started.

17. Has the member attempted any of the following drugs for ankylosing spondylitis:
leflunomide, methotrexate, non-steroidal anti-inflammatory drugs (NSAIDs) or sulfasalazine? Yes No

If yes, indicate the drug name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section VI of this form.

18. Has the member attempted other drugs for ankylosing spondylitis
(e.g., glucocorticoids or IV immunomodulators such as infliximab)? Yes No

If yes, indicate the drug name(s), dose, specific details about the treatment response, and the approximate dates each drug was taken in the space provided. If additional space is needed, continue documentation in Section VI of this form.

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED CYTOKINE AND CAM ANTAGONIST DRUG REQUESTS (PA requests for non-preferred cytokine and CAM antagonist drugs must be submitted on paper.)

19. Indicate the cytokine and CAM antagonist drugs the member has taken and provide specific details regarding the treatment response. If additional space is needed, continue documentation in Section VI of this form.

Note: A copy of the member’s medical records must be submitted with the PA request to support the condition being treated, details regarding previous medication use, and outline the member’s current treatment plan.

1. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

2. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

3. Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

20. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.

SECTION IV – AUTHORIZED SIGNATURE

21. SIGNATURE – Prescriber

22. Date Signed

SECTION V – 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 (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.)

Continued

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA (Continued)

27. Place of Service

28. Assigned PA Number

29. Grant Date

30. Expiration Date

31. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

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