**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-11304 (01/2022)

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

**FORWARDHEALTH**

# PRIOR AUTHORIZATION DRUG ATTACHMENT 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 Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis Instructions, F-11304A. 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 Drug Attachment for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form signed and dated by the prescriber before 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 – Prescriber |
|---|---|

## SECTION III – CLINICAL INFORMATION FOR ANKYLOSING SPONDYLITIS

12. Diagnosis Code and Description

**Note: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.**

| | | |
|---|---|---|
| 13. Does the member have ankylosing spondylitis? | ❑ Yes | ❑ No |
| 14. Is the prescription written by a rheumatologist or through a rheumatology consultation? | ❑ Yes | ❑ No |

DT-PA072-072

15. Is the member currently using the requested non-preferred cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, indicate the approximate date therapy was started.

16. Indicate the preferred cytokine and CAM antagonist drugs the member has taken and provide specific details regarding member's response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form.

1. Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

_____

_____

2. Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

_____

_____

3. Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

_____

_____

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

**SECTION IV – AUTHORIZED SIGNATURE**

| 18. **SIGNATURE** – Prescriber | 19. Date Signed |
|---|---|
| | |

**SECTION V – ADDITIONAL INFORMATION**

20. 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