DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11306 (01/2019)

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 PSORIASIS

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 Psoriasis Instructions, F-11306A. 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 Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form signed by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. 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 – Prescriber

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

11. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION FOR PSORIASIS

12. Diagnosis Code and Description

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.

13. Does the member have psoriasis? ❑ Yes ❑ No

If yes, indicate the areas affected and the approximate percent of body surface area involved.

14. Is the prescription written by a dermatologist or through a dermatology consultation? ❑ Yes ❑ No

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SECTION III – CLINICAL INFORMATION FOR PSORIASIS (Continued)

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

    If yes, indicate the approximate date therapy was started.

16. Has the member attempted any of the following drugs or therapies for psoriasis: cyclosporine, methotrexate, phototherapy, or acitretin? ❑ Yes ❑ No

    If yes, indicate the drug or therapy 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 V of this form.

17. Has the member attempted other drugs for psoriasis (for example, topicals, 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 more space is needed, continue documentation in Section V of this form.

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SECTION III – CLINICAL INFORMATION FOR PSORIASIS (Continued)

18. Indicate the cytokine and CAM antagonist drug(s) the member has taken and provide specific details regarding the treatment response. If more space is needed, continue documentation in Section V of this form.

    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

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

SECTION IV – AUTHORIZED SIGNATURE

20. **SIGNATURE** – Prescriber	21. Date Signed

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SECTION V – ADDITIONAL INFORMATION

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