DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11306 (01/2026)

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. 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 Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form signed and dated by the prescriber before 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. 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 PSORIASIS (Required for All PA Requests)

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

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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 the 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 III A – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED ADALIMUMAB-XXXX PA REQUESTS

18. PA requests for a non-preferred adalimumab-xxxx drug must include detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. This clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR OTEZLA XR PA REQUESTS

19. PA requests for Otezla XR must include detailed clinical justification for prescribing Otezla XR instead of Otezla. This clinical information must document why the member cannot use Otezla, including why it is medically necessary that the member receive Otezla XR instead of Otezla.

SECTION III C – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED USTEKINUMAB-XXXX SUBQ PA REQUESTS

20. PA requests for a non-preferred ustekinumab-xxxx subQ drug must include detailed clinical justification for prescribing a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. This clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

SECTION IV – AUTHORIZED SIGNATURE

21. **SIGNATURE** – Prescriber	22. Date Signed

SECTION V – ADDITIONAL INFORMATION

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

Reset Form