**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-11306 (05/2023)

**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 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 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 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 |

DT-PA074-074

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 III A – ADDITIONAL CLINICAL INFORMATION FOR ADALIMUMAB-XXXX REQUESTS**

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

**SECTION IV – AUTHORIZED SIGNATURE**

| 19. **SIGNATURE** – Prescriber | 20. Date Signed |
|---|---|
| | |

## SECTION V – ADDITIONAL INFORMATION

21. 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