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

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 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

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   ____

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.