FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, F-11097A. Providers 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/Preferred Drug List (PA/PDL) for Stimulants and Related Agents form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification 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 (NPI) — Prescriber

10. Address — Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS (Providers are required to complete Section III and either Section IIIA or Section IIIB.)

12. Diagnosis Code and Description

SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS REQUESTS (Excluding Kapvay.)

13. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants? ❑ Yes ❑ No

If yes, list the preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

1. _____
2. _____
3. _____
4. _____

Continued

SECTION IIIB — CLINICAL INFORMATION FOR KAPVAY REQUESTS ONLY

14. Will the member take Kapvay in combination with a preferred stimulant? ❑ Yes ❑ No

If yes, list the preferred stimulant in the space provided.

15. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a preferred stimulant? ❑ Yes ❑ No

If yes, list the preferred stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the preferred stimulant was taken in the space provided.

16. Does the member have a medical condition(s) preventing the use of a preferred stimulant? ❑ Yes ❑ No

If yes, list the medical condition(s) that prevents the use of a preferred stimulant in the space provided.

17. Is there a clinically significant drug interaction between another medication the member is taking and a preferred stimulant? ❑ Yes ❑ No

If yes, list the medication(s) and interaction(s) in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

18. **SIGNATURE** — Prescriber	19. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 Digits)	21. Days' Supply Requested (Up to 365 Days)

22. NPI

23. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.)

24. Place of Service

25. Assigned PA Number

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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

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