

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR MIGRAINE AGENTS, OTHER**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other Completion Instructions, F-00280A. 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 Migraine Agents, Other 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, 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 Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

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

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least **three** preferred drugs from the Migraine Agents, Other drug class? Yes No

If yes, list the drug name and dates the drug was taken in the space provided for **each** of the **three** preferred drugs the member has taken from the Migraine Agents, Other drug class.

Drug Name _____ Dates Taken _____

Drug Name _____ Dates Taken _____

Drug Name _____ Dates Taken _____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

Continued



SECTION IV — AUTHORIZED SIGNATURE

15. SIGNATURE — Prescriber

16. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

17. National Drug Code (11 Digits)

18. Days' Supply Requested (Up to 365 Days)

19. NPI

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

21. Place of Service

22. Assigned PA Number

23. Grant Date

24. Expiration Date

25. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

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