

FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions, F-11075A.

Pharmacy providers are required to have a completed PA/PDL Exemption Request form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION	
1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

SECTION II — PRESCRIPTION INFORMATION	
4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI)
10. Address and Telephone Number — Prescriber (Street, City, State, ZIP+4 Code, and Telephone Number)	

SECTION III — CLINICAL INFORMATION	
11. Diagnosis — Primary Code and / or Description	
12. Has the member experienced treatment failure with the preferred drug(s)? If "yes," list the most recently failed preferred drug(s), specific details of the treatment failure(s), and the approximate date(s) the preferred drug(s) was taken.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Does the member have a medical condition(s) that prevents the use of the preferred drug(s)? If "yes," list the medical condition(s) in the space provided.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Is there a clinically significant drug interaction between another medication the member is taking and the preferred drug(s)? If "yes," list the medication(s) and interaction(s) in the space provided.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Has the member experienced a clinically significant adverse drug reaction while taking the preferred drug(s)? If "yes," list the preferred drug(s) that caused the adverse drug reaction, specific details of the adverse reaction, and the approximate date(s) the preferred drug(s) was taken.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. For grandfathered classes, including, but not limited to, anti-Parkinson agents, selective serotonin reuptake inhibitor (SSRI) antidepressants, other antidepressants, anticonvulsants, and atypical antipsychotics, has the member taken the requested non-preferred medication for more than 30 days outside ForwardHealth and had a measurable, therapeutic response?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No

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SECTION III— CLINICAL INFORMATION (Continued)

17. SIGNATURE — Prescriber	18. Date Signed
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SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

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

22. 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.)

23. Patient Location (Use patient location code "0" [Not Specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)

24. Assigned PA Number

25. Grant Date	26. Expiration Date	27. Number of Days Approved
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SECTION V — ADDITIONAL INFORMATION

28. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a member who was granted retroactive eligibility by ForwardHealth.
