**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.10(2), Wis. Admin. Code

F-00281 (07/2013)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR FENTANYL MUCOSAL AGENTS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions, F-00281A. Providers may refer to the Forms page of the ForwardHealth Portal at [https://*www.forwardhealth.wi.gov/WIPortal/subsystem/publications/forwardhealthcommunications.aspx?panel=Forms*](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 Fentanyl Mucosal 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, by fax, or by mail. Providers may call Provider Services at 800- 947-9627 with questions.

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| **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. Does the member have cancer that is causing persistent pain? [ ]  Yes [ ]  No |
| 15. Is the member tolerant to around-the-clock opioid therapy for his or her underlying,persistent cancer pain? [ ]  Yes [ ]  No |
| 16. Is the member currently taking a long-acting opioid analgesic drug(s)? [ ]  Yes [ ]  NoIf yes, list the long-acting opioid analgesic drug(s) and dose(s) the member is currently taking in the space provided.Drug Name       Daily Dose      Drug Name       Daily Dose       |

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**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR FENTANYL MUCOSAL AGENTS** Page 2 of 2

F-00281 (07/2013)

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| **SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)** |
| 17. Does the member experience breakthrough cancer pain that is not relieved by othershort-acting opioid analgesic drug(s)? [ ]  Yes [ ]  NoIf yes, list the short-acting opioid analgesic drug(s) and dose(s) the member has previously taken in the space provided.Drug Name       Daily Dose      Drug Name       Daily Dose       |
| **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 183 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 and / 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 be included here.       |