**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  No  If 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 | |

*Continued*

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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 other  short-acting opioid analgesic drug(s)?  Yes  No  If 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. | | | |