FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR NON-PREFERRED STIMULANTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Non-Preferred Stimulants Completion Instructions, F-01672A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Non-Preferred Stimulants 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. 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

12. Diagnosis Code and Description

13. Has the member taken Vyvanse® for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response? ☐ Yes ☐ No

If yes, list the dose, dosage adjustments, specific details about the unsatisfactory therapeutic response, and the approximate dates that Vyvanse® was taken in the space provided.

Continued

SECTION III – CLINICAL INFORMATION (Continued)

14. Has the member taken Vyvanse® and experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

    If yes, list the dose, specific details about the significant adverse drug reaction, and the approximate dates that Vyvanse® was taken in the space provided.

15. Has the member taken a methylphenidate stimulant for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response? ☐ Yes ☐ No

    If yes, list the methylphenidate stimulant, dose, dosage adjustments, specific details about the unsatisfactory therapeutic response, and the approximate dates that the methylphenidate stimulant was taken in the space provided.

16. Has the member taken a methylphenidate stimulant and experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

    If yes, list the methylphenidate stimulant, dose, specific details about the significant adverse drug reaction, and the approximate dates that the methylphenidate stimulant was taken in the space provided.

17. Has the member taken a dexmethylphenidate stimulant for at least 60 consecutive days with a minimum of one dosage adjustment and experienced an unsatisfactory therapeutic response? ☐ Yes ☐ No

    If yes, list the dexmethylphenidate stimulant, dose, dosage adjustments, specific details about the unsatisfactory therapeutic response, and the approximate dates that the dexmethylphenidate stimulant was taken in the space provided.

18. Has the member taken a dexmethylphenidate stimulant and experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

    If yes, list the dexmethylphenidate stimulant, dose, specific details about the significant adverse drug reaction, and the approximate dates that the dexmethylphenidate stimulant was taken in the space provided.

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SECTION IV – AUTHORIZED SIGNATURE

19. **SIGNATURE** – Prescriber	20. Date Signed

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 Digits)	22. Days' Supply Requested (Up to 365 Days)

23. NPI

24. 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.)

25. Place of Service

26. Assigned PA Number

27. Grant Date	28. Expiration Date	29. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

30. 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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