**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-01950 (01/2025)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR CROHN’S DISEASE AND ULCERATIVE COLITIS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn’s Disease and Ulcerative Colitis Instructions, F‑01950A. Prescribers may refer to the Forms page of the ForwardHealth Portal at [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 Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn’s Disease and Ulcerative Colitis form signed and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy 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 ID 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. Address – Prescriber (Street, City, State, Zip+4 Code) | |
| 10. Phone Number – Prescriber | 11. National Provider Identifier – Prescriber |
| **SECTION III – CLINICAL INFORMATION FOR CROHN’S DISEASE AND ULCERATIVE COLITIS (Required for All PA Requests)** | |
| 12. Diagnosis Code and Description    **Note:** **Supporting clinical information and a copy of the member’s current medical records must be submitted with all PA requests.** | |
| 13. Does the member have Crohn’s disease?  Yes  No | |
| 14. Does the member have ulcerative colitis?  Yes  No | |

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| 15. Is the prescription written by a gastroenterologist or through a gastroenterology  consultation?  Yes  No |
| 16. Is the member currently using the requested non-preferred cytokine and  CAM antagonist drug?  Yes  No  If yes, indicate the approximate date therapy was started. |
| 17. Indicate the preferred cytokine and CAM antagonist drugs the member has taken, and provide specific details regarding the member’s response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form.  1. Drug Name       Dose       Dates Taken  Description of Treatment Response and Reason(s) for Discontinuing    2. Drug Name       Dose       Dates Taken  Description of Treatment Response and Reason(s) for Discontinuing    3. Drug Name       Dose       Dates Taken  Description of Treatment Response and Reason(s) for Discontinuing |
| 18. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug. |
| **SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED ADALIMUMAB-XXXX PA REQUESTS** |
| 19. PA requests for a non-preferred adalimumab-xxxx drug must include detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. This clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. |

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| **SECTION III B – ADDITIONAL CLINICAL INFORMATION FOR XELJANZ XR PA REQUESTS** | | |
| 20. PA requests for Xeljanz XR must include detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. This clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz. | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | |
| 21. **SIGNATURE** – Prescriber | 22. Date Signed | |
| **SECTION V – ADDITIONAL INFORMATION** | |
| 23. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here. | |