**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-01952 (01/2025)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR GIANT CELL ARTERITIS AND NON‑RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA)**

**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 Giant Cell Arteritis and Non-Radiographic Axial Spondyloarthritis (nr-axSpA) Instructions, F‑01952A. Prescribers may refer to the Forms page of the ForwardHealth Portal at [forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms](http://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 Giant Cell Arteritis and nr-axSpA form signed and dated by the prescriber before submitting a 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 (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.** |

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| **SECTION III A – CLINICAL INFORMATION FOR GIANT CELL ARTERITIS ONLY** |
| 13. Does the member have giant cell arteritis? [ ]  Yes [ ]  No |
| 14. Is the prescription written by a rheumatologist or through a rheumatology consultation? [ ]  Yes [ ]  No |
| 15. Is the member currently using the requested non-preferred drug? [ ]  Yes [ ]  NoIf yes, indicate the approximate date therapy was started. |
| 16. Has the member taken Tyenne subQ for **at least three** consecutive months andexperienced an unsatisfactory therapeutic response or a clinically significantadverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the Tyenne subQ dose and dates taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction. If additional space is needed, continue documentation in Section V of this form.Dose:       Dates Taken:      Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.       |
| 17. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.      |

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| **SECTION III B – CLINICAL INFORMATION FOR NR-AXSPA ONLY** |
| 18. Does the member have nr-axSpA? [ ]  Yes [ ]  No |
| 19. Is the prescription written by a rheumatologist or through a rheumatology consultation? [ ]  Yes [ ]  No |
| 20. Is the member currently using the requested non-preferred drug? [ ]  Yes [ ]  NoIf yes, indicate the approximate date therapy was started.      |
| 21. Has the member taken Cimzia for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the Cimzia dose and dates taken and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction. If additional space is needed, continue documentation in Section V of this form.Dose:       Dates Taken:      Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.       |
| 22. Indicate the clinical reason(s) why the prescriber is requesting a non-preferred cytokine and CAM antagonist drug.       |
| **SECTION IV – AUTHORIZED SIGNATURE** |
| 23. **SIGNATURE** – Prescriber | 24. Date Signed |
| **SECTION V – ADDITIONAL INFORMATION** |
| 25. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.       |