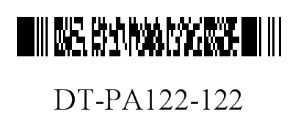
**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-02433 (04/2021)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR EPIDIOLEX**

**INSTRUCTIONS:** Type of print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Epidiolex Instructions, F-02433A. 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%20) for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Epidiolex 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 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. National Provider Identifier – Prescriber |
| 10. Address – Prescriber (Street, City, State, Zip+4 Code) | | |
| 11. Phone Number – Prescriber | | |
| **SECTION III – CLINICAL INFORMATION – ALL REQUESTS** | | |
| 12. Diagnosis Code and Description | | |
| 13. Does the member have Lennox-Gastaut syndrome?  Yes  No | | |
| 14. Does the member have tuberous sclerosis complex?  Yes  No | | |
| 15. Does the member have Dravet syndrome?  Yes  No | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | |
| 16. **SIGNATURE** – Prescriber | | 17. Date Signed |

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| **SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA** | | | |
| 18. National Drug Code (11 Digits) | | 19. Days’ Supply Requested (Up to 365 Days) | |
| 20. National Provider Identifier | | | |
| 21. 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.) | | | |
| 22. Place of Service | | | |
| 23. Assigned PA Number | | | |
| 24. Grant Date | 25. Expiration Date | | 26. Number of Days Approved |
| **SECTION VI – ADDITIONAL INFORMATION** | | | |
| 27. 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. | | | |