**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-02572 (01/2025)

**STATE OF WISCONSIN**
Wis. Admin. Code § DHS 107.10(2)

**FORWARDHEALTH**

# PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR IMMUNOMODULATORS, ATOPIC DERMATITIS – TOPICAL

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Immunomodulators, Atopic Dermatitis–Topical Instructions, F-02572A. Prescribers may refer to the Forms page of the ForwardHealth Portal at 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 Immunomodulators, Atopic Dermatitis–Topical form signed and dated 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. Prescribers and pharmacy providers may call Provider Services at 800-947-9627 with questions.

## 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 (NPI) – Prescriber |
|---|---|

## SECTION III – CLINICAL INFORMATION

12. Diagnosis Code and Description

13. Does the member have atopic dermatitis? ❑ Yes ❑ No

14. Has the member used Eucrisa for at least two consecutive months and experienced an unsatisfactory therapeutic response? ☐ Yes ☐ No

If yes, list specific details about the unsatisfactory therapeutic response and the approximate dates that Eucrisa was used in the space provided.

15. Has the member used Eucrisa and experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

If yes, list specific details about the clinically significant adverse drug reaction and the approximate dates that Eucrisa was used in the space provided.

16. Has the member used a topical calcineurin inhibitor for at least two consecutive months and experienced an unsatisfactory therapeutic response? ☐ Yes ☐ No

If yes, list the name and strength of the topical calcineurin inhibitor used, specific details about the unsatisfactory therapeutic response, and the approximate dates that the topical calcineurin inhibitor was used in the space provided.

17. Has the member used a topical calcineurin inhibitor and experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

If yes, list the name and strength of the topical calcineurin inhibitor used, specific details about the clinically significant adverse drug reaction, and the approximate dates that the topical calcineurin inhibitor was used in the space provided.

**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 365 Days) |
|---|---|

22. NPI

23. Date of Service (DOS) (mm/dd/ccyy) (For STAT-PA requests, the DOS may be up to 31 days in the future 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 also be included here.

Reset Form