**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-02572 (09/2022)

**FORWARDHEALTH**

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

**FOR EUCRISA AND OPZELURA FOR ATOPIC DERMATITIS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Eucrisa and Opzelura for Atopic Dermatitis Instructions, F-02572A. Prescribers 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) for the completion instructions.

Pharmacy providers are required to have a completed PA/PDL for Eucrisa and Opzelura for Atopic Dermatitis 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.

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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 (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 a topical steroid for at least two consecutive months and experienced an unsatisfactory therapeutic response? [ ]  Yes [ ]  NoIf yes, list the name and strength of the topical steroid, specific details about the unsatisfactory therapeutic response, and the approximate dates that the topical steroid was taken in the space provided.       |
| 15. Has the member used a topical steroid and experienced a clinically significantadverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the name and strength of the topical steroid, specific details about the clinically significant adverse drug reaction, and the approximate dates that the topical steroid was used in the space provided.       |
| 16. Has the member used Elidel or Protopic for at least two consecutive monthsand experienced an unsatisfactory therapeutic response? [ ]  Yes [ ]  NoIf yes, list the name and strength of the drug used, specific details about the unsatisfactory therapeutic response, and the approximate dates that Elidel or Protopic was used in the space provided.      |
| 17. Has the member used Elidel or Protopic and experienced a clinically significantadverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the name and strength of the drug used, specific details about the significant adverse drug reaction, and the approximate dates that Elidel or Protopic 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 (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.)       |
| 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.       |