FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HEADACHE AGENTS, TRIPTANS NON-INJECTABLE

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Headache Agents, Triptans Non-Injectable Instructions, F-02668A. Providers may refer to the Forms page of the ForwardHealth Portal at 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/Preferred Drug List (PA/PDL) for Headache Agents, Triptans Non-Injectable 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.

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. Refills

8. Directions for Use

9. Name – Prescriber	10. National Provider Identifier – Prescriber

11. Address – Prescriber (Street, City, State, Zip+4 Code)

12. Phone Number – Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

DT-PA130-130

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least three** preferred drugs from the headache agents, triptans non-injectable drug class? ❑ Yes ❑ No

If yes, list the drug name and date(s) the drug was taken in the space provided for **each** of the **three** preferred drugs the member has taken from the headache agents, triptans non-injectable drug class.

Drug Name ____ Date(s) Taken ___________________________

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Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

SECTION IV – AUTHORIZED SIGNATURE

15. **SIGNATURE** – Prescriber	16. Date Signed

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

17. National Drug Code (11 Digits)	18. Days' Supply Requested (Up to 365 Days)

19. National Provider Identifier

20. 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.)

21. Place of Service

22. Assigned PA Number

23. Grant Date	24. Expiration Date	25. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

26. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.