DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03174 (01/2025)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR HIDRADENITIS SUPPURATIVA

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 Hidradenitis Suppurativa Instructions, F-03174A. 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 Drug Attachment for Cytokine and CAM Antagonist Drugs for Hidradenitis Suppurativa form signed and dated by the prescriber before submitting a prior authorization (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 – Prescriber

SECTION III – CLINICAL INFORMATION FOR HIDRADENITIS SUPPURATIVA (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.

13. Does the member have hidradenitis suppurativa?	❑ Yes	❑ No
14. Is the prescription written by a dermatologist or through a dermatology consultation?	❑ Yes	❑ No

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15. Is the member currently using the requested non-preferred cytokine and CAM antagonist drug? ❑ Yes ❑ No

If yes, indicate the approximate date therapy was started.

16. Has the member taken Cyltezo or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, list the name and dose of the drug used and the 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.

Name _____ 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.

SECTION III A – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED ADALIMUMAB-XXXX PA REQUESTS

18. PA requests for a non-preferred adalimumab-xxxx drug must include detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira. This clinical information must document why the member cannot use Cyltezo and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Cyltezo and Humira.

SECTION IV – AUTHORIZED SIGNATURE

19. **SIGNATURE** – Prescriber	20. Date Signed

SECTION V – ADDITIONAL INFORMATION

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

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