**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-11306 (01/2025)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS FOR PSORIASIS**

**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 Psoriasis Instructions, F-11306A. Prescribers may refer to the Forms page of the ForwardHealth Portal at [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 Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis 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.

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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 – Prescriber      |
| **SECTION III – CLINICAL INFORMATION FOR PSORIASIS (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 psoriasis? [ ]  Yes [ ]  No |
| 14. Is the prescription written by a dermatologist or through a dermatology consultation? [ ]  Yes [ ]  No |
| 15. Is the member currently using the requested non-preferred cytokine and CAM antagonist drug? [ ]  Yes [ ]  NoIf yes, indicate the approximate date therapy was started.      |
| 16. Indicate the preferred cytokine and CAM antagonist drugs the member has taken and provide specific details regarding member’s response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form.1. Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuing      2. Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuing     3. Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuing       |
| 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 adalimumab-xxxx instead of Cyltezo and Humira.       |
| **SECTION IV – AUTHORIZED SIGNATURE** |
| 19. **SIGNATURE** – Prescriber | 20. Date Signed |

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| **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.      |