

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

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is only used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain drugs. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the PA request. Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

**INSTRUCTIONS**

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis form, F-11306. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form to request PA by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

Pharmacy providers may submit PA requests on a PA drug attachment form in one of the following ways:

- For PA requests submitted on the Portal, pharmacy providers may access [forwardhealth.wi.gov/](https://forwardhealth.wi.gov/).
- For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA drug attachment form to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
313 Blettner Blvd  
Madison WI 53784

Pharmacy providers and prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I – MEMBER INFORMATION**

**Element 1: Name – Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth ID card and the EVS do not match, use the spelling from the EVS.

**Element 2: Member ID Number**

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

**Element 3: Date of Birth – Member**

Enter the member's date of birth in mm/dd/ccyy format.

## **SECTION II – PRESCRIPTION INFORMATION**

### **Element 4: Drug Name**

Enter the drug name.

### **Element 5: Drug Strength**

Enter the strength of the drug listed in Element 4.

### **Element 6: Date Prescription Written**

Enter the date the prescription was written.

### **Element 7: Directions for Use**

Enter the directions for use of the drug.

### **Element 8: Name – Prescriber**

Enter the name of the prescriber.

### **Element 9: Address – Prescriber**

Enter the address (street, city, state, and zip+4 code) of the prescribing provider.

### **Element 10: Phone Number – Prescriber**

Enter the phone number, including the area code, of the prescribing provider.

### **Element 11: National Provider Identifier – Prescriber**

Enter the prescribing provider's National Provider Identifier.

## **SECTION III – CLINICAL INFORMATION FOR PSORIASIS (Required for All PA Requests)**

Include diagnostic and clinical information explaining the need for the drug requested. Complete all elements in Section III. Check Yes or No as it applies to each question. Include written documentation as indicated.

### **Element 12 – Diagnosis Code and Description**

Enter the appropriate and most specific International Classification of Diseases (ICD) diagnosis code and description most relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

**Note: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.**

### **Element 13**

Check the appropriate box to indicate whether or not the member has psoriasis.

### **Element 14**

Check the appropriate box to indicate whether or not the prescription was written by a dermatologist or through a dermatology consultation.

### **Element 15**

Check the appropriate box to indicate whether or not the member is currently using the requested non-preferred cytokine and CAM antagonist drug. If yes, indicate the approximate date therapy was started.

### **Element 16**

Indicate the preferred cytokine and CAM antagonist drugs the member has taken, including drug name, dose, dates taken, and details regarding the member's treatment response and reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of the form.

### **Element 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**

#### **Element 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**

#### **Element 19: Signature – Prescriber**

The prescriber is required to complete and sign this form.

#### **Element 20: Date Signed**

Enter the month, day, and year the form was signed in mm/dd/ccyy format.

### **SECTION V – ADDITIONAL INFORMATION**

#### **Element 21**

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