DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00433 (07/2022)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) ORALLY DISINTEGRATING TABLETS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets Instructions, F-00433A. Prescribers 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 Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets 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.

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

11. Phone Number – Prescriber	12. National Provider Identifier (NPI) – Prescriber

SECTION III – CLINICAL INFORMATION (Required for All Requests)

13. Diagnosis Code and Description

14. Is the member 5 years of age or older? ☐ Yes ☐ No

15. Does the member have a medical condition(s) that prevents the use of PPI capsules and non-orally disintegrating tablets? ☐ Yes ☐ No

If yes, list the medical condition(s) and describe how it prevents the member from using PPI capsules and non-orally disintegrating tablets.

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Nexium DR packet? ☐ Yes ☐ No

If yes, list the dates Nexium DR packet was taken. _____

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

17. Is there a clinically significant drug interaction between another drug the member is taking and Nexium DR packet? ☐ Yes ☐ No

If yes, list the drug(s) and interaction(s) in the space provided.

18. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Protonix suspension? ☐ Yes ☐ No

If yes, list the dates Protonix suspension was taken. _____

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

19. Is there a clinically significant drug interaction between another drug the member is taking and Protonix suspension? ☐ Yes ☐ No

If yes, list the drug(s) and interaction(s) in the space provided.

SECTION IV – AUTHORIZED SIGNATURE

20. **SIGNATURE** – Prescriber	21. Date Signed

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

22. National Drug Code (11 Digits)	23. Days' Supply Requested (Up to 365 Days)

24. NPI

25. Date of Service (DOS) (mmd/dd/ccyy) (For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.)

26. Place of Service

27. Assigned PA Number

28. Grant Date	29. Expiration Date	30. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

31. 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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