JUNE 2026 | NO. 2026-15

ForwardHealth UPDATE

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JULY 2026 PREFERRED DRUG LIST CHANGES AND OTHER PHARMACY POLICY

On May 6, 2026, the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee met to review existing therapeutic drug classes on the Preferred Drug List (PDL).

This ForwardHealth Update announces changes to the PDL and certain PDL drug classes from the May 2026 PDL review, certain PA form changes, and other pharmacy policy changes.

All policy and form changes are effective July 1, 2026, unless otherwise noted.

Providers may refer to the ForwardHealth Online Handbook Standard Pharmacy Policy for Covered and Noncovered Drugs topic #22337 for general ForwardHealth policy for drugs that require PA approval. Providers may also refer to this topic about what may **not** be considered criteria to support the need for a drug.

Providers are responsible for staying current with ForwardHealth policy and procedures and billing information in the Online Handbook.

AFFECTED PROGRAMS

BadgerCare Plus, Medicaid, SeniorCare

TO

Blood Banks, Community Health Centers, Dentists, Hospital Providers, Nurse Practitioners, Nursing Homes, Pharmacies, Pharmacists, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, Tribal Federally Qualified Health Centers, HMOs and Other Managed Care Programs

CONTACT INFORMATION

Provider Services and the Drug Authorization and Policy Override (DAPO) Center, 800-947-9627

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WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Refer to the following sections for more information about:

- Drug status changes on the PDL.
- Changes to pharmacy-related PA forms and instructions.
- A brief overview of the PDL.
- New weight management agents drug class.
- Changes to antibiotics, beta-lactam drug class.
- Changes to antibiotics, inhaled drug class.
- Changes to cytokine and cell adhesion molecule antagonists drug class.
- Changes to growth hormone drug class.
- Changes to H. pylori drug class.
- Changes to headache agents, preventative treatment drug class.
- Changes to hypoglycemics, glucagon-like peptide drug class.
- Changes to immunomodulators, atopic dermatitis drug class.
- Changes to multiple sclerosis agents, other drug class.
- Changes to opioid dependency agents drug class.
- Changes to proton pump inhibitors drug class.
- Changes to ulcerative colitis drug class.
- Other pharmacy policy changes.

Drug Status Changes on the Preferred Drug List

Attachment A to this Update lists the drugs that have changed their preferred or non-preferred status as a result of the May 2026 PDL review. The Preferred Drug List Quick Reference data table contains a complete list of preferred and non-preferred drugs.

For drugs that were previously preferred and will become non-preferred, pharmacy providers should work with prescribers to transition members to a preferred drug or complete the appropriate PA request forms for non-preferred drugs.

As a reminder, new drugs are usually added to existing drug classes on the PDL as non-preferred drugs until the next scheduled drug class review by the Wisconsin Medicaid Pharmacy PA Advisory Committee. This means that some drugs listed in the table have not previously been reviewed and were added to the PDL with an interim status of non-preferred. These drugs have now been reviewed, and their PDL status is included in Attachment A.

Changes to Pharmacy-Related PA Forms and Instructions

Attachment B lists the PA forms and instructions that have been revised,

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revised and renamed, or discontinued as a result of the May 2026 PDL review or as a result of other pharmacy policy changes. The Forms page of the ForwardHealth Portal (the Portal) contains current copies of all PA forms and instructions.

More information regarding changes to clinical criteria or PA request submission options is noted in the applicable drug class or other pharmacy policy sections of this Update.

Archive Page for Pharmacy-Related Forms and Instructions

The Pharmacy-Related Forms and Instructions link under the Archives Quick Links box on the Pharmacy Resources page of the Portal contains previous versions of pharmacy-related forms and instructions for reference purposes.

A Brief Overview of the Preferred Drug List

ForwardHealth makes recommendations to the Wisconsin Medicaid Pharmacy PA Advisory Committee about whether certain PDL drugs should be preferred or non-preferred. These recommendations are based primarily on objective evaluations of a drug's relative safety, effectiveness, clinical outcomes, and relative cost (to Wisconsin Medicaid) in comparison with other therapeutically interchangeable, alternative agents in the same drug class.

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Wisconsin Medicaid Pharmacy PA Advisory Committee.

The PDL is not a drug formulary and is not a comprehensive list of covered drugs.

Current PA Policy for Preferred Drug List Drugs

The responsibilities of prescribers and pharmacy providers for PA for PDL drugs are addressed in the Online Handbook.

- A Prescriber's Responsibilities for Prior Authorization for Preferred Drug List Drugs topic #1987
- A Pharmacy Provider's Responsibilities for Prior Authorization for Preferred Drug List Drugs topic #10937

Note: These topics will be updated on July 1, 2026.

DID YOU KNOW?

Prescribers and pharmacy providers can find specific pharmacy-related PA forms on the Forms page by entering the form number into the Keyword or Form Number field of the Search Criteria and clicking Search.

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Most drugs and drug classes included on the PDL are covered fee for service by BadgerCare Plus, Wisconsin Medicaid, and SeniorCare, but certain drugs may have restrictions (for example, diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA, except in designated classes identified on the Preferred Drug List Quick Reference data table.

New Weight Management Agents Drug Class

Effective July 1, 2026, ForwardHealth will add weight management agents as a new drug class to the PDL.

Foundayo and Zepbound will become preferred drugs in the weight management agents drug class.

PA will be required for all weight management agents, including preferred weight management agents. Weight management agents that are not included in this PDL drug class or do not have separate established clinical criteria are noncovered services.

Weight management agents are covered for dual eligibles enrolled in a Medicare Part D Prescription Drug Plan.

PA requests for weight management agents will only be approved for **one** weight management agent per member at a time. ForwardHealth does not cover treatment with more than one weight management agent at a time.

Note: Refer to the Anti-Obesity Drugs No Longer Covered section of this Update for the list of anti-obesity drugs that will no longer be covered effective July 1, 2026. Refer to the Wegovy Injection and Wegovy Tablets section for the new and revised clinical criteria for Wegovy.

New Clinical Criteria for Weight Management Agents

ForwardHealth has established the clinical PA criteria for weight management agents.

Clinical criteria for approval of a PA request for weight management agents require **one** of the following:

- The member has a body mass index (BMI) greater than or equal to 30.

QUICK LINKS

Drug Authorization and Policy Override Center topic #7857

Note: This topic will be updated on July 1, 2026.

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- The member has a BMI greater than or equal to 27 but less than 30 **and** has two or more of the following risk factors:
  - Dyslipidemia
  - Hypertension
  - Sleep apnea
  - Type 2 diabetes mellitus
  - Cardiovascular disease supported by a history of at least one of the following:
    - Myocardial infarction (heart attack)
    - Coronary revascularization
    - Angina pectoris
    - Stroke
    - Intermittent claudication with an ankle-brachial index (ABI) of less than or equal to 0.9
    - Peripheral arterial revascularization due to atherosclerotic disease or amputation due to atherosclerotic disease

In addition, the member must agree to follow a reduced-calorie diet and increase their physical activity.

If the clinical criteria for weight management agents are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests require the member to have a reduction in BMI compared to their baseline prior to the initiation of the weight management agent. Renewal PA requests for weight management agents may be approved for up to 365 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

PA renewal requests for weight management agents will not be approved if a member's BMI is below 18.5.

Revised and Renamed PA Form for Weight Management Agents

ForwardHealth has revised and renamed the Prior Authorization Drug Attachment for Anti-Obesity Drugs form, F-00163 (11/2025), to the Prior Authorization Drug Attachment for Weight Management Agents, F-00163 (07/2026).

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Effective July 1, 2026, prescribers, or their designees, must submit PA requests for weight management agents on the Prior Authorization Drug Attachment for Weight Management Agents form (dated 07/2026). ForwardHealth will return PA requests that are not submitted on the revised and renamed form.

ForwardHealth will honor PA requests for Zepbound submitted on the Prior Authorization Drug Attachment for Anti-Obesity Drugs form (dated 11/2025) and approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Weight Management Agents

Prescribers, or their designees, must request PA for weight management agents using one of the following options:

- The DAPO Center
- The Portal
- Fax
- Mail

Pharmacy providers may not request PA for weight management agents.

A prescriber, or their designee, should have all PA information completed before calling the DAPO Center to obtain PA.

Prescribers are required to retain a completed copy of the Prior Authorization Drug Attachment for Weight Management Agents form and any supporting documentation.

If a prescriber or their designee chooses to submit a paper PA request for weight management agents by fax or mail, the following must be completed and submitted to ForwardHealth:

- Prior Authorization Request Form (PA/RF), F-11018 (04/2026)
- Prior Authorization Drug Attachment for Weight Management Agents form
- Supporting documentation, as appropriate

The Prior Authorization Fax Cover Sheet, F-01176 (12/2025), is available on the Forms page of the Portal for prescribers or their designees submitting the forms and documentation by fax.

As a reminder, prescribers must complete, sign, and date the PA/RF and the Prior Authorization Drug Attachment for Weight Management Agents form when submitting the PA request on paper.

QUICK LINKS

Forms page

HOURS OF OPERATION

Hours of operation for the DAPO Center are from 8 a.m.–5:30 p.m., Monday–Friday. After business hours and on weekends, providers may leave a voicemail message for DAPO Center staff to return the next business day.

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Changes to Antibiotics, Beta-Lactam Drug Class

Cefpodoxime suspension will remain a non-preferred drug in the antibiotics, beta-lactam drug class. Non-preferred drugs require PA.

Effective July 1, 2026, PA for cefpodoxime suspension will not be required for members 12 years of age and under.

PA for cefpodoxime suspension will, however, be required for members age 13 or older. PA requests for cefpodoxime suspension for members age 13 or older must be submitted using the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form, F-11075 (07/2023).

Changes to Antibiotics, Inhaled Drug Class

Non-preferred drugs in the antibiotics, inhaled drug class require PA.

Tobi Podhaler and Cayston require clinical PA.

Revised Clinical Criteria for Tobi Podhaler

ForwardHealth has revised the clinical criteria for Tobi Podhaler.

Clinical criteria that must be documented for approval of a PA request for Tobi Podhaler are **all** of the following:

- The member has cystic fibrosis.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. Prescribers are required to include a copy of the sputum culture report with all PA requests.
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member is not receiving treatment with other inhaled antibiotics or anti-infective agents, including alternating treatment schedules. Prescribers are required to provide a history of all inhaled antibiotics or anti-infective agents within the most recent 90-day period.
- The prescriber has submitted detailed clinical justification for prescribing Tobi Podhaler instead of Bethkis, Kitabis Pak, or tobramycin solution (generic Tobi), including clinical information describing why the member cannot use Bethkis, Kitabis Pak, or tobramycin solution (generic Tobi), and why it is medically necessary that the member receive Tobi Podhaler instead of Bethkis, Kitabis Pak, or tobramycin solution (generic Tobi).
- The member has been adherent with their prescribed treatment regimen for inhaled medications.

QUICK LINKS

- Non-Preferred Drugs That Use the Prior Authorization/Preferred Drug List Exemption Request Form topic #22218
- Antibiotics, Inhaled topic #9837

Note: Topic #9837 will be updated on July 1, 2026.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Tobi Podhaler. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Initial PA requests for Tobi Podhaler may be approved for up to 183 days.

Renewal PA requests for Tobi Podhaler may be approved for up to 365 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Cayston

ForwardHealth has revised the clinical criteria for Cayston.

Clinical criteria that must be documented for approval of a PA request for Cayston are **all** of the following:

- The member has cystic fibrosis.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. Prescribers are required to include a copy of the sputum culture report with all PA requests.
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member is not receiving treatment with other inhaled antibiotics or anti-infective agents, including alternating treatment schedules. Prescribers are required to provide a history of all inhaled antibiotics or anti-infective agents within the most recent 90-day period.
- At least **one** of the following is true:
  - The member has previously used inhaled tobramycin and experienced a clinically significant adverse drug reaction or an unsatisfactory therapeutic response.
  - The member has a medical condition(s) that prevents the use of inhaled tobramycin.
- The member has been adherent with their prescribed treatment regimen for inhaled medications.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Cayston. The supporting

NEVER MISS A MESSAGE

Stay current on policies and procedures by signing up for Portal text messages or email alerts! These alerts let providers know when there is a new secure Portal message. Go to the **Message Center** on the secure Portal and click **Notification Preferences**. Section 12.4 of the ForwardHealth Provider Portal Account User Guide (PDF) has detailed instructions.

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clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Initial PA requests for Cayston may be approved for up to 183 days.

Renewal PA requests for Cayston may be approved for up to 365 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Cayston for Continuous Alternating Therapy

ForwardHealth has revised the clinical criteria for Cayston for continuous alternating therapy (CAT).

Clinical criteria that must be documented for approval of a PA request for Cayston for CAT are **all** of the following:

- The member has cystic fibrosis.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. Prescribers are required to include a copy of the sputum culture report with all PA requests.
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member is experiencing persistent exacerbations or forced expiratory volume in one second decline with no significant improvement while using a single inhaled antibiotic drug or significant worsening of other markers that are being regularly tracked to monitor pulmonary disease progression.
- The prescriber has provided specific treatment goals for the member's CAT.
- The prescriber has provided a history of all inhaled antibiotics or anti-infective agents within the most recent 90-day period.
- The member has been adherent with their prescribed treatment regimen for inhaled medications.

Note: ForwardHealth will not consider CAT as an initial choice for inhaled antibiotic therapy.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Cayston for CAT. The

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supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Initial PA requests for Cayston for CAT may be approved for up to 183 days.

Renewal PA requests for Cayston for CAT may be approved for up to 365 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Non-Preferred Drugs in the Antibiotics, Inhaled Drug Class

PA requests for non-preferred drugs in the antibiotics, inhaled drug class must be completed, signed, and dated by the prescriber. PA requests for non-preferred drugs in the antibiotics, inhaled drug class must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the Prior Authorization/Drug Attachment (PA/DGA) form, F-11049 (01/2024). Clinical documentation supporting the use of non-preferred drugs in the antibiotics, inhaled drug class must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred drugs in the antibiotics, inhaled drug class may be submitted on the Portal, by fax, or by mail (but **not** using the Specialized Transmission Authorization Technology [STAT-PA] system).

The following indicate how PA requests for non-preferred drugs in the antibiotics, inhaled drug class will be approved when the clinical criteria have been met:

- PA requests will be approved for up to a maximum 28-day supply per dispensing.

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- PA requests will be approved with an alternating 28-day treatment schedule of 28 days of a non-preferred drug in the antibiotics, inhaled drug class with 28 days of no inhaled antibiotics or anti-infective agents.

Note: The alternating 28-day treatment schedule with 28 days of no inhaled antibiotics or anti-infective agents previously listed does not apply to approved PA requests for Cayston for CAT treatment. When PA is approved for Cayston for CAT, members may alternate between two inhaled antibiotics or anti-infective agents.

Changes to Cytokine and Cell Adhesion Molecule Antagonists Drug Class

New Non-Preferred Drugs Icotyde and Tocilizumab-XXXX

Icotyde and tocilizumab-xxxx will become non-preferred drugs in the cytokine and cell adhesion molecule antagonists drug class. Non-preferred cytokine and cell adhesion molecule (CAM) antagonist drugs require PA.

Icotyde and tocilizumab-xxxx will have an interim status of non-preferred and will be reviewed during the November 2026 PDL review.

Icotyde will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat psoriasis.

Tocilizumab-xxxx will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat these clinical conditions:

- Giant cell arteritis
- Juvenile idiopathic arthritis (JIA) and systemic JIA
- Rheumatoid arthritis (RA)

The clinical criteria and PA submissions for non-preferred drugs used to treat giant cell arteritis, JIA and systemic JIA, and RA have not changed.

New Indication for Sotyktu

Sotyktu, a non-preferred cytokine and CAM antagonist drug, has been approved to treat psoriatic arthritis.

Sotyktu will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis.

QUICK LINKS

Cytokine and Cell Adhesion Molecule Antagonist Drugs topic #16217

Note: This topic will be updated on July 1, 2026.

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Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease.

Cimzia, Hadlima, Humira, Selarsdi subQ, and Steqeyma subQ are preferred drugs used to treat Crohn's disease. Preferred cytokine and CAM antagonist drugs do not require PA.

Adalimumab-xxxx, Entyvio subQ, Omvoh subQ, Rinvoq, Skyrizi subQ, Stelara subQ, Tremfya subQ, ustekinumab-xxxx subQ, and Zymfentra are non-preferred drugs used to treat Crohn's disease.

Note: Omvoh and Skyrizi will require an IV induction prior to initiating treatment with the subQ. A PA request for the IV induction must be approved before ForwardHealth will consider PA for the subQ. PA for the IV induction may be obtained through the physician-administered drug PA process. An IV induction for Tremfya is optional prior to initiating treatment with the subQ.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
  - Hadlima or Humira as one trial.
  - Selarsdi subQ or Steqeyma subQ as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

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Stelara subQ and Non-Preferred Ustekinumab-xxxx subQ Drugs

The prescriber must submit detailed clinical justification for prescribing Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

Revised PA Form for Cytokine and Cell Adhesion Molecule Antagonist Drugs Used to Treat Crohn's Disease and Ulcerative Colitis

ForwardHealth has revised the Prior Authorization Drug Attachment for the Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form, F-01950 (07/2026).

Effective July 1, 2026, pharmacy providers must use the revised form to submit PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease or ulcerative colitis. ForwardHealth will return PA requests that are not submitted with the revised form.

ForwardHealth will honor PA requests approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should not submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form and a completed PA/RF to ForwardHealth.

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PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis.

Cimzia, Enbrel, Hadlima, Humira, Otezla, Selarsdi subQ, Steqeyma subQ, and Taltz are preferred drugs used to treat psoriasis. Preferred cytokine and CAM antagonist drugs do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, Icotyde, Otezla XR, Skyrizi subQ, Sotyktu, Stelara subQ, Tremfya, and ustekinumab-xxxx subQ are non-preferred drugs used to treat psoriasis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis are **all** of the following:

- The member has psoriasis.
- The prescription is written by a dermatologist or through a dermatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
  - Hadlima or Humira as one trial.
  - Selarsdi subQ or Steqeyma subQ as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

When initially accessing Online Handbook topic links available throughout this Update, providers need to click the "I Accept" button at the bottom of the licensure agreement page of the Online Handbook. After 30 minutes of inactivity, providers will need to click "I Accept" again before going to their intended topic.

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Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Stelara subQ and Non-Preferred Ustekinumab-xxxx subQ Drugs

The prescriber must submit detailed clinical justification for prescribing Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

Otezla XR

The prescriber must submit detailed clinical justification for prescribing Otezla XR instead of Otezla. The clinical information must document why the member cannot use Otezla, including why it is medically necessary that the member receive Otezla XR instead of Otezla.

Revised PA Form for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis

ForwardHealth has revised the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis form, F-11306 (07/2026).

Effective July 1, 2026, pharmacy providers must use the revised form to submit PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis. ForwardHealth will return PA requests that are not submitted with the revised form.

ForwardHealth will honor PA requests approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred

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cytokine and CAM antagonist drugs used to treat psoriasis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis.

Cimzia, Enbrel, Hadlima, Humira, Orencia subQ, Otezla, Selarsdi subQ, Simponi subQ, Steqeyma subQ, Taltz, Xeljanz, and Xeljanz XR are preferred drugs used to treat psoriatic arthritis. Preferred cytokine and CAM antagonist drugs do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, Otezla XR, Rinvoq, Rinvoq LQ, Skyrizi subQ, Sotyktu, Stelara subQ, Tremfya subQ, and ustekinumab-xxxx subQ are non-preferred drugs used to treat psoriatic arthritis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis are **all** of the following:

- The member has psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an

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unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
    - Hadlima or Humira as one trial.
    - Selarsdi subQ or Steqeyma subQ as one trial.
    - Xeljanz or Xeljanz XR as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Otezla XR

The prescriber must submit detailed clinical justification for prescribing Otezla XR instead of Otezla. The clinical information must document why the member cannot use Otezla, including why it is medically necessary that the member receive Otezla XR instead of Otezla.

Stelara SubQ and Non-Preferred Ustekinumab-xxxx SubQ Drugs

The prescriber must submit detailed clinical justification for prescribing Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

Revised PA Form for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, and Psoriatic Arthritis

ForwardHealth has revised the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis form, F-01951 (07/2026).

Effective July 1, 2026, pharmacy providers must use the revised form to submit PA requests for non-preferred cytokine and CAM antagonist drugs

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used to treat RA, JIA, and psoriatic arthritis. ForwardHealth will return PA requests that are not submitted with the revised form.

ForwardHealth will honor PA requests approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis.

Hadlima, Humira, Selarsdi subQ, Simponi subQ, Steqeyma subQ, Xeljanz, and Xeljanz XR are preferred drugs used to treat ulcerative colitis. Preferred cytokine and CAM antagonist drugs do not require PA.

Adalimumab-xxxx, Entyvio subQ, Omvoh subQ, Rinvoq, Skyrizi subQ, Stelara subQ, Tremfya subQ, ustekinumab-xxxx subQ, and Zymfentra are non-preferred drugs used to treat ulcerative colitis.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Note: Omvoh and Skyrizi will require an IV induction prior to initiating treatment with the subQ. A PA request for the IV induction must be approved before ForwardHealth will consider PA for the subQ. PA for the IV induction may be obtained through the physician-administered drug PA process. An IV induction for Tremfya is optional prior to initiating treatment with the subQ.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
  - Hadlima or Humira as one trial.
  - Selarsdi subQ or Steqeyma subQ as one trial.
  - Xeljanz or Xeljanz XR as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Stelara subQ and Non-Preferred Ustekinumab-xxxx subQ Drugs

The prescriber must submit detailed clinical justification for prescribing Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive Stelara subQ or a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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Changes to Growth Hormone Drug Class

Revised Clinical Criteria for Growth Hormone Drug Coverage for Children and Adolescents

ForwardHealth has revised the clinical criteria for growth hormone drugs for children and adolescents.

ForwardHealth covers growth hormone drugs for children and adolescents when prescribed in a manner consistent with Food and Drug Administration (FDA)-approved product labeling for the following indications:

- The member has a history of panhypopituitarism involving at least two pituitary hormone deficiencies, not including growth hormone, and a history of hypothalamic-pituitary structural lesion(s).
- The member has a history of cranial irradiation, tumor, or other structural midline lesion, in addition to a decreasing growth velocity and a low insulin-like growth factor-1 (IGF-1) measurement below the age- and gender-specific lower limit of normal with normal thyroid function and adequate nutrition.

QUICK LINKS

Growth Hormone Drugs topic #1988

Note: This topic will be updated on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- The member has growth failure or short stature associated with one of the following congenital conditions that have an FDA-approved indication for growth hormone use:
  - Noonan syndrome
  - Prader-Willi syndrome
  - SHOX gene deficiency disorder
  - Turner syndrome
- The member has growth failure or short stature associated with chronic renal insufficiency in pre-kidney transplant members.
- The member is born small for gestational age (SGA) in addition to being at least 24 months-old with a height that remains more than two standard deviations below the mean for chronological age and gender on a clinically appropriate growth chart. SGA is defined as infants with a birth weight and/or height below the 10th percentile for gestational age. Other causes for short stature must have been excluded, such as growth inhibiting medication, chronic disease, thyroid disease, or under-nutrition. ForwardHealth will consider the entire clinical record for the PA request determination decision.
- The member has growth failure or short stature for children and adolescents with growth hormone deficiency including **all** of the following:
  - The member's height is more than two standard deviations below the mean for chronological age and gender on a clinically appropriate growth chart.
  - Other causes for short stature must have been excluded, such as growth inhibiting medication, chronic disease, other congenital conditions, thyroid disease, or under-nutrition. If IGF-1 levels are low, insulin-like growth factor-binding protein 3 (IGFBP-3) testing should be considered, and under-nutrition should be evaluated and addressed before proceeding with growth hormone stimulation testing. If the results of the IGF-1/IGFBP-3 and bone age are normal, best clinical practice would indicate growth hormone stimulation testing is not necessary since growth hormone deficiency can effectively be excluded without the need for further testing due to recognized limitations of growth hormone stimulation testing and risk of false positive results.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- The member has failed to respond to at least two validated growth hormone stimulation tests performed using a well-standardized protocol demonstrating a growth hormone peak response of less than 10 ng/mL after stimulation with a pharmacologic agent such as insulin, arginine, clonidine, or glucagon.

Growth Hormone Stimulation Testing Requirements for Children and Adolescents

Growth hormone stimulation testing should be conducted after an overnight fast using a well-standardized protocol and should be conducted for the appropriate duration of time specific to the agents used to ensure the peak growth hormone level is captured. Both stimulation tests can be administered the same day.

When growth hormone stimulation testing has been performed, complete testing results must be submitted with the PA request, including the following:

- Confirmation that the member was fasting
- The type of stimulation test and the dose of stimulating agent
- A copy of the medical notes taken during the entire testing procedure, including vital signs and blood glucose levels
- The time and results from each blood sample taken
- Provider interpretation of the testing results

For members with thyroid deficiency, ForwardHealth only accepts results of the growth hormone stimulation tests that are performed after thyroid deficiency is adequately treated because growth hormone secretion may be subnormal merely as a result of hypothyroidism.

Growth hormone stimulation testing performed in a non-validated or sub-standard manner will not be considered by ForwardHealth to be an acceptable growth hormone stimulation test.

Growth hormone testing can provide useful information, but due to the recognized limitations of growth hormone stimulation testing and the risk of false positive results, ForwardHealth will consider the results of the growth hormone stimulation testing in the context of the entire clinical record for the PA request determination decision.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Documentation Requirements for PA Requests for Growth Hormone for Children and Adolescents

Detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment must be submitted with the PA request, including the following:

- Detailed endocrinology and medical work-up, including medical problem list, current medication list, and medication history
- Height and weight measurements over time plotted on the most clinically appropriate growth chart(s) for age and gender, including growth velocity, growth percentiles, and Z-scores
- Copies of the member's gestational age, weight at birth, and length at birth (if required)
- Copies of the most recent IGF-1 and IGFBP-3 lab reports
- Bone age results
- Thyroid-stimulating hormone level
- Nutritional assessment
- Any other relevant testing, such as advanced imaging of the hypothalamic-pituitary region, if performed

Submitting PA Requests for Growth Hormone Drugs for Children and Adolescents

PA requests for growth hormone drugs for children and adolescents must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, F-11092 (07/2024). PA requests for growth hormone drugs for children and adolescents may be submitted using the STAT-PA system when the member meets both of the following:

- The member has growth failure or short stature associated with one of the following congenital conditions:
  - Noonan syndrome
  - Prader-Willi syndrome
  - SHOX gene deficiency disorder
  - Turner syndrome
- The member is younger than 14 years of age.

All other PA requests for preferred or non-preferred growth hormone drugs for children and adolescents may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

If the clinical criteria for growth hormone drugs for children and adolescents are met, initial PA requests may be approved for up to 183 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current endocrinology clinic notes, including clinically appropriate height and weight growth charts for age and gender, the most current IGF-1 and/or IGFBP-3 lab testing results, growth velocity, and the most current bone age report, must be included with the PA request. Renewal PA requests may be approved for up to 365 days.

Clinical Criteria for Growth Hormone Drugs for Adults

The clinical criteria and PA submission options for growth hormone drugs for adults have not changed.

Clinical Criteria for Serostim

The clinical criteria and PA submission options for Serostim have not changed.

Changes to H. Pylori Drug Class

Revised Clinical Criteria for Voquezna Tablets

ForwardHealth has revised the clinical criteria for Voquezna tablets.

The clinical criteria for approval of a PA request for Voquezna tablets are **all** of the following:

- The member's age must be consistent with FDA-approved product labeling for Voquezna tablets.
- **One** of the following is true:
  - The member has erosive esophagitis.
  - The member has healed erosive esophagitis.
  - The member has non-erosive gastroesophageal reflux disease.
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** proton pump inhibitors (PPIs).

Supporting clinical information and a copy of the member's current medical records must be submitted with the PA request to support the member's condition and outline the member's current treatment plan.

If the clinical criteria for Voquezna tablets are met, PA requests may be approved for up to 183 days.

QUICK LINKS

H. Pylori Drugs topic #23258

Note: This topic will be updated on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Revised PA Form for Voquezna

ForwardHealth has revised the Prior Authorization Drug Attachment for Voquezna Tablets form, F-03384 (07/2026).

Effective July 1, 2026, pharmacy providers must use the revised form to submit PA requests for Voquezna tablets. ForwardHealth will return PA requests that are not submitted with the revised form.

ForwardHealth will honor PA requests approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Voquezna Tablets

PA requests for Voquezna tablets must be completed, signed, and dated by the prescriber. PA requests for Voquezna tablets must be submitted using the Prior Authorization Drug Attachment for Voquezna Tablets form. Clinical documentation supporting the use of Voquezna tablets must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Voquezna Tablets form and a completed PA/RF to ForwardHealth.

PA requests for Voquezna tablets may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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Changes to Headache Agents, Preventative Treatment Drug Class

Revised Clinical Criteria for Non-Preferred Headache Agents, Preventative Treatment Drugs

ForwardHealth has revised the clinical criteria for non-preferred headache agents, preventative treatment drugs.

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Headache Agents, Preventative Treatment topic #21117

Note: This topic will be updated on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Clinical criteria for approval of an initial PA request for non-preferred headache agents, preventative treatment drugs are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The prescriber has evaluated and diagnosed the member as having a history of migraines, with or without aura, according to International Classification of Headache Disorders, 3rd edition, diagnostic criteria.
- The member is compliant with the prescribed headache medication treatment regimen and continues to experience four or more migraine headache days per month.
- The member's current prescribed migraine medication treatment regimen must be documented. The prescriber is required to indicate the member's current migraine preventative and rescue medications (drug name[s], dose, and dosing frequency), including Botox (if applicable).
- The member has taken two preferred headache agents, preventative treatment drugs for the preventative treatment of migraines for at least three consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests (initial, initial renewal, and subsequent renewal) for non-preferred headache agents, preventative treatment drugs. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

The medical records must demonstrate that the member meets the clinical criteria and document the member's medical work-up for migraines, including the current number of headache days per month, the number of migraine days per month, and the average migraine duration (in hours), as well as complete problem and medication lists.

If the clinical criteria for non-preferred headache agents, preventative treatment drugs are met, initial PA requests may be approved for up to 183 days.

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Initial Renewal PA Requests for Non-Preferred Headache Agents, Preventative Treatment Drugs

Clinical criteria that must be documented for approval of initial renewal PA requests for non-preferred headache agents, preventative treatment drugs are **all** of the following:

- The member experienced a clinically significant decrease in the number of migraine days per month and/or a decrease in migraine duration compared to their baseline prior to initiation of treatment with a non-preferred headache agent, preventative treatment drug.
- The member's current prescribed migraine medication treatment regimen has been documented. The prescriber is required to indicate the member's current migraine preventative and rescue medications (drug name[s], dose, and dosing frequency), including Botox (if applicable).
- The member has been compliant with their prescribed migraine medication treatment regimen.

Initial renewal PA requests for non-preferred headache agents, preventative treatment drugs may be approved for up to 365 days.

Subsequent Renewal PA Requests for Non-Preferred Headache Agents, Preventative Treatment Drugs

Clinical criteria that must be documented for approval of subsequent renewal PA requests for non-preferred headache agents, preventative treatment drugs are **all** of the following:

- The member has sustained a clinically significant decrease in the number of migraine days per month and/or a decrease in migraine duration compared to their baseline prior to initiation of treatment with a non-preferred headache agent, preventative treatment drug.
- The current number of headache days per month, the number of migraine days per month, and the average migraine duration (in hours) must be documented.
- The member's current prescribed migraine headache medication treatment regimen has been documented. The prescriber is required to indicate the member's current migraine preventative and rescue medications (drug name[s], dose, and dosing frequency), including Botox (if applicable).
- The member has been compliant with their prescribed migraine medication treatment regimen.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Subsequent renewal PA requests for non-preferred headache agents, preventative treatment drugs may be approved for up to 365 days.

Submitting PA Requests for Non-Preferred Headache Agents, Preventative Treatment Drugs

PA requests for non-preferred headache agents, preventative treatment drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred headache agents, preventative treatment drugs must be submitted using the Prior Authorization Drug Attachment for Headache Agents, Preventative Treatment form, F-02667 (07/2022). Clinical documentation supporting the use of non-preferred headache agents, preventative treatment drugs must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Headache Agents, Preventative Treatment form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred headache agents, preventative treatment drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Changes to Hypoglycemics, Glucagon-Like Peptide Drug Class

Mounjaro will become a preferred drug in the hypoglycemics, glucagon-like peptide drug class. Preferred hypoglycemics, glucagon-like peptide (GLP-1) agents do not require PA.

Clinical Criteria for Non-Preferred Hypoglycemics, Glucagon-Like Peptide Agents

The clinical criteria and PA submission options for non-preferred hypoglycemics, GLP-1 agents have not changed.

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The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Changes to Immunomodulators, Atopic Dermatitis Drug Class

New Clinical Condition

ForwardHealth has added a new clinical condition, allergic fungal rhinosinusitis (AFRS), to the list of clinical conditions for non-preferred immunomodulators, atopic dermatitis drugs that require PA.

PA requests for non-preferred immunomodulators, atopic dermatitis drugs will only be approved for use to treat the identified clinical conditions:

- AFRS
- Atopic dermatitis
- Bullous pemphigoid
- Chronic obstructive pulmonary disease
- Chronic rhinosinusitis with nasal polyposis
- Chronic spontaneous urticaria
- Eosinophilic esophagitis
- Eosinophilic asthma
- Oral corticosteroid dependent asthma
- Prurigo nodularis

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for non-preferred immunomodulators, atopic dermatitis drugs. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Note: If a member has more than one clinical condition for which ForwardHealth will approve a non-preferred immunomodulators, atopic dermatitis drug and the provider would like to bypass the required trial of a ForwardHealth-preferred biologic drug, the provider must submit complete medical records for the clinical conditions. Additionally, the provider must clearly identify on the PA/DGA form that the member has more than one clinical condition for which the non-preferred drug is approved and provide justification for bypassing the required ForwardHealth-preferred biologic drug. ForwardHealth will use the member's complete clinical picture to evaluate the PA request.

QUICK LINKS

Immunomodulators, Atopic Dermatitis topic #8857

Note: This topic will be updated on July 1, 2026.

New Clinical Criteria for Immunomodulators, Atopic Dermatitis Drugs for Allergic Fungal Rhinosinusitis

ForwardHealth has established the clinical PA for non-preferred immunomodulators, atopic dermatitis drugs for AFRS.

Dupixent is a non-preferred drug used to treat AFRS.

Clinical criteria that must be documented for approval of a PA request for non-preferred drugs used to treat AFRS are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the requested drug.
- The prescription is written by or through consultation with an allergist or an ear, nose, and throat specialist.
- The member has AFRS with a history of sino-nasal surgery.
- The member was appropriately treated with post-surgical glucocorticoids and has been compliant with therapy.
- The results of a sinus computed tomography (CT) study showing nasal polyposis with opacification of one or more sinuses must be submitted.
- The member will not use the requested drug in combination with any biologic immunomodulator.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have AFRS must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant reduction in AFRS symptoms.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Immunomodulators, Atopic Dermatitis Drugs for Allergic Fungal Rhinosinusitis

PA requests for non-preferred immunomodulators, atopic dermatitis drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred immunomodulators, atopic dermatitis drugs must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical

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documentation supporting the use of non-preferred immunomodulators, atopic dermatitis drugs must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Changes to Multiple Sclerosis Agents, Other Drug Class

Copaxone 20 mg and Copaxone 40 mg will become brand medically necessary (BMN) drugs and will require BMN PA.

The generic drug, glatiramer, is a preferred drug in the multiple sclerosis agents, other drug class. Preferred drugs in this drug class do not require PA.

Revised Clinical Criteria for Glatopa

ForwardHealth has revised the clinical criteria for Glatopa.

The prescriber must submit detailed clinical justification for prescribing Glatopa instead of glatiramer. The clinical information must document why the member cannot use glatiramer, including why it is medically necessary that the member receive Glatopa instead of glatiramer.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Glatopa. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Initial and Renewal PA Requests for Glatopa

If the clinical criteria for Glatopa are met, initial PA requests may be approved for up to 183 days. Renewal PA requests may be approved for up to 365 days.

QUICK LINKS

- Multiple Sclerosis Agents, Other topic #22897
- Brand Medically Necessary Drugs: A Prescriber's Responsibilities topic #2016
- Brand Medically Necessary Drugs: A Pharmacy Provider's Responsibilities topic #2017

Note: Topic #22897 will be updated on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Renewal PA requests for Glatopa must include copies of the member's current medical records demonstrating that the member's multiple sclerosis is stable and well-controlled without having disease-progressing symptoms.

All renewal PA requests for Glatopa require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Glatopa

PA requests for Glatopa must be completed, signed, and dated by the prescriber. PA requests for Glatopa must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Glatopa may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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Changes to Opioid Dependency Agents Drug Class

Opioid Dependency Agents—Buprenorphine

Buprenorphine tablets (without naloxone) will become a preferred drug and will no longer require PA.

Clinical Criteria for Non-Preferred Opioid Dependency Agents—Buprenorphine

Effective July 1, 2026, the clinical criteria for non-preferred drugs submitted on the PA/PDL Exemption Request form will also apply to non-preferred opioid dependency agents—buprenorphine drugs, unless otherwise noted.

Clinical Criteria for Non-Preferred Drugs Submitted With the Prior Authorization/Preferred Drug List Exemption Request Form

Clinical criteria for approval of a PA request for a non-preferred drug

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Opioid Dependency Agents topic #8917

Note: This topic will be removed from the Online Handbook on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

submitted with the PA/PDL Exemption Request form are **at least one** of the following:

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.
- There is a clinically significant drug interaction between another drug the member is taking and **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.
- The member has a medical condition(s) that prevents the use of **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.

Discontinued Prior Authorization/Preferred Drug List for Opioid Dependency—Buprenorphine Form

Effective July 1, 2026, the Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents—Buprenorphine form, F-00081 (07/2024), is being discontinued and will no longer be accepted. It will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal.

ForwardHealth will honor PA requests for opioid dependency agents—buprenorphine drugs approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Non-Preferred Opioid Dependency Agents—Buprenorphine Drugs on the Prior Authorization/Preferred Drug List Exemption Request Form

PA requests for non-preferred drugs submitted with the PA/PDL Exemption Request form must be completed, signed, and dated by the prescriber. PA requests for non-preferred drugs designated to use the PA/PDL Exemption Request form must be submitted using the PA/PDL Exemption Request form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

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Pharmacy providers are required to submit the completed PA/PDL Exemption Request form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred drugs submitted with the PA/PDL Exemption Request form may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

Changes to Proton Pump Inhibitors Drug Class

Non-preferred drugs in the proton pump inhibitors drug class require PA. Preferred drugs in the proton pump inhibitors drug class do not require PA.

Revised Clinical Criteria for Non-Preferred Proton Pump Inhibitor Drugs

ForwardHealth has revised the clinical criteria for non-preferred PPI drugs.

Clinical criteria for approval of a PA request for a non-preferred PPI requires one of the following to be true:

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** preferred PPIs.
- The member has a medical condition(s) that prevents the use of the preferred PPIs.

If the clinical criteria for non-preferred PPIs are met, PA requests may be approved for up to 365 days.

QUICK LINKS

Proton Pump Inhibitors topic #8877

Note: This topic will be updated on July 1, 2026.

Revised and Renamed Prior Authorization/Preferred Drug List for Proton Pump Inhibitor Capsules, Suspensions, and Non-Orally Disintegrating Tablets Form

ForwardHealth has revised and renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules, Suspensions, and Non-Orally Disintegrating Tablets form, F-11078 (07/2022), to Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitors (PPIs) form, F-11078 (07/2026).

Effective July 1, 2026, pharmacy providers must submit PA requests for non-preferred PPI drugs on the PA/PDL for PPIs form (dated 07/2026). ForwardHealth will return PA requests that are not submitted on the revised and renamed form.

ForwardHealth will honor PA requests for non-preferred PPI drugs submitted on the PA/PDL for PPI Capsules, Suspensions, and Non-Orally Disintegrating

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The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Tablets form (dated 07/2022) approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Discontinued Prior Authorization/Preferred Drug List for Proton Pump Inhibitor Orally Disintegrating Tablets Form

Effective July 1, 2026, the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets form, F-00433 (07/2022), is being discontinued and will no longer be accepted. It will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal.

ForwardHealth will honor PA requests for PPI drugs submitted on the PA/PDL for PPI Orally Disintegrating Tablets form (dated 07/2022) approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Submitting PA Requests for Non-Preferred Proton Pump Inhibitor Drugs

PA requests for non-preferred PPIs must be completed, signed, and dated by the prescriber. PA requests for non-preferred PPIs must be submitted on the PA/PDL for PPIs form (dated 07/2026).

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the appropriately completed PA/PDL form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred PPIs may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

Changes to Ulcerative Colitis Drug Class

Revised Clinical Criteria for Velsipity and Zeposia for Members With Ulcerative Colitis

ForwardHealth has revised the clinical criteria for Velsipity and Zeposia for members with ulcerative colitis.

Clinical criteria that must be documented for approval of a PA request for

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Velsipity or Zeposia for members with ulcerative colitis are **all** of the following:

- The member has moderate to severe ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- **Two** of the following are true:
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Simponi subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Xeljanz or Xeljanz XR for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Velsipity or Zeposia for members with ulcerative colitis. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Velsipity or Zeposia for members with ulcerative colitis are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Velsipity or Zeposia for members with ulcerative colitis may be approved for up to 365 days. Renewal PA requests for members who have ulcerative colitis must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant reduction in symptoms compared to the member's baseline prior to the initiation of the non-preferred drug.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

QUICK LINKS

Ulcerative Colitis topic #22578

Note: This topic will be updated on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Submitting PA Requests for Velsipity or Zeposia for Members With Ulcerative Colitis

PA requests for Velsipity or Zeposia for members with ulcerative colitis must be completed, signed, and dated by the prescriber. PA requests for Velsipity or Zeposia for members with ulcerative colitis must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of Velsipity or Zeposia must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Velsipity or Zeposia for members with ulcerative colitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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Other Pharmacy Policy Changes

Achondroplasia Drugs

The FDA has approved Yuviwel to treat achondroplasia.

Clinical PA is required for all achondroplasia drugs. Voxzogo and Yuviwel are achondroplasia drugs that require PA.

Revised Clinical Criteria for Achondroplasia Drugs

ForwardHealth has revised the clinical criteria for achondroplasia drugs.

The following clinical criteria must be met and documented for approval of a PA request for achondroplasia drugs:

- The member has achondroplasia.
- The achondroplasia drug must be prescribed in a dose and manner consistent with FDA-approved product labeling.
- The member's current height, weight, and growth velocity has been provided.
- The provider has submitted evidence that the member has open epiphyses.

QUICK LINKS

Voxzogo topic #22377

Note: This topic will be updated and the topic title renamed Achondroplasia Drugs on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for achondroplasia drugs. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for achondroplasia drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for achondroplasia drugs may be approved for up to 365 days. Renewal PA requests must include copies of the member's current medical records demonstrating that the member had an increase in their growth velocity compared to their baseline prior to the initiation of the achondroplasia drug.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Achondroplasia Drugs

PA requests for achondroplasia drugs must be completed, signed, and dated by the prescriber. PA requests for achondroplasia drugs must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth. PA requests for achondroplasia drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Anti-Obesity Drugs No Longer Covered

Effective July 1, 2026, the following anti-obesity drugs will no longer be covered:

- Benzphetamine

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The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- Diethylpropion
- Orlistat
- Phendimetrazine
- Phentermine
- Phentermine/topiramate
- Evekeo (for obesity)
- Saxenda
- Xenical

ForwardHealth will honor PA requests for these anti-obesity drugs submitted on the Prior Authorization Drug Attachment for Anti-Obesity Drugs form and approved before July 1, 2026, until they expire or until the approved days' supply is used up.

Providers should refer to the new weight management agents drug class on the PDL for available treatment options.

Imcivree

New Clinical Condition for Imcivree

ForwardHealth has added a new clinical condition, hypothalamic obesity (HO), to the list of clinical conditions for the use of Imcivree that require PA.

Conditions for Which PA Requests for the Use of Imcivree Will Be Considered for Review

PA requests for Imcivree will only be approved to reduce excess body weight and maintain weight reduction long term for members with the identified clinical conditions:

- Bardet-Biedl Syndrome (BBS)
- HO
- Proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency

New Clinical Criteria for Imcivree for Members With Hypothalamic Obesity

ForwardHealth has established the clinical PA criteria for Imcivree for members with HO.

Clinical criteria that must be documented for approval of a PA request for Imcivree for members with HO are **all** of the following:

- Imcivree must be prescribed in a dose and manner consistent with FDA-approved product labeling.

QUICK LINKS

- Anti-Obesity Drugs topic #7837
- Imcivree topic #22819

Note: On July 1, 2026, topic #7837 will be removed from the Online Handbook and topic #22819 will be updated.

- The prescription is written by an endocrinologist or geneticist or through an endocrinology or genetics consultation.
- The member's current height, weight, and BMI are documented.
- The member has HO.
- The prescriber has evaluated the member and determined that the member does not have any medical or medication contraindications to treatment with Imcivree.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Imcivree for members with HO. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Imcivree for members with HO are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Imcivree for members with HO may be approved for up to 365 days. Renewal PA requests for members who have HO must include supporting clinical information and copies of the member's current medical records demonstrating that the member's weight or BMI (for patients with continued growth potential) remains at least 5% below the member's baseline weight or their BMI.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Imcivree for Members With Bardet-Biedl Syndrome

ForwardHealth has revised the clinical criteria for Imcivree for members with BBS.

Clinical criteria that must be documented for approval of a PA request for Imcivree for members with BBS are **all** of the following:

- Imcivree must be prescribed in a dose and manner consistent with FDA-approved product labeling.
- The prescription is written by an endocrinologist or geneticist or through an endocrinology or genetics consultation.

- The member's current height, weight, and BMI are documented.
- The member has BBS.
- The prescriber has evaluated the member and determined that the member does not have any medical or medication contraindications to treatment with Imcivree.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Imcivree for members with BBS. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Imcivree for members with BBS are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Imcivree for members with BBS may be approved for up to 365 days. Renewal PA requests for members who have BBS must include supporting clinical information and copies of the member's current medical records demonstrating that the member's weight or BMI (for patients with continued growth potential) remains at least 5% below the member's baseline weight or their BMI.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Imcivree for Members With a Proopiomelanocortin, Proprotein Convertase Subtilisin/Kexin Type 1, or Leptin Receptor Deficiency

ForwardHealth has revised the clinical criteria for members with a POMC, PCSK1, or LEPR deficiency.

Clinical criteria that must be documented for approval of a PA request for Imcivree for members with a POMC, PCSK1, or LEPR deficiency are **all** of the following:

- Imcivree must be prescribed in a dose and manner consistent with FDA-approved product labeling.
- The prescription is written by an endocrinologist or geneticist or through an endocrinology or genetics consultation.

- The member's current height, weight, and BMI are documented.
- The member has a POMC, PCSK1, or LEPR deficiency confirmed by genetic testing demonstrating variants in POMC, PCSK1, or LEPR genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance. (Note: A copy of the genetic testing results must be submitted with the PA request.)
- The prescriber has evaluated the member and determined that the member does not have any medical or medication contraindications to treatment with Imcivree.

A copy of the member's current medical records must be submitted with all PA requests for Imcivree for members with a POMC, PCSK1, or LEPR deficiency. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Imcivree for members with a POMC, PCSK1, or LEPR deficiency are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Imcivree for members with a POMC, PCSK1, or LEPR deficiency may be approved for up to 365 days. Renewal PA requests for members who have a POMC, PCSK1, or LEPR deficiency must include supporting clinical information and copies of the member's current medical records demonstrating that the member's weight or BMI (for patients with continued growth potential) remains at least 5% below the member's baseline weight or their BMI.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Imcivree

PA requests for Imcivree must be completed, signed, and dated by the prescriber. PA requests for Imcivree must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of Imcivree must be submitted with the PA request.

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The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Imcivree may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Jynarque and Tolvaptan

Effective July 1, 2026, the clinical criteria for Jynarque will also apply to tolvaptan.

Revised Clinical Criteria for Jynarque and Tolvaptan

ForwardHealth has revised the clinical criteria for Jynarque and tolvaptan.

The following clinical criteria must be met and documented for approval of a PA request for Jynarque or tolvaptan:

- The member's age must be consistent with FDA-approved product labeling for the requested drug.
- The member has autosomal dominant polycystic kidney disease.
- The prescription is written by, or in consultation with, a nephrologist or kidney transplant specialist.
- The member has an estimated glomerular filtration rate (eGFR) equal to or greater than 25 mL/min per 1.73 m^2.
- The member has a high risk for progression to end-stage renal disease due to **one** or more of the following:
  - A confirmed annual eGFR decline of at least 5 mL/min/1.73 m^2 in one year
  - A confirmed annual eGFR decline of at least 2.5 mL/min/1.73 m^2 per year over a period of five years
  - A greater than 5% increase in total kidney volume per year on at least three repeated measurements (via CT or MRI, each at least six months apart)
  - A truncated polycystic kidney disease 1 mutation and early clinical signs (for example, hypertension, macroscopic hematuria, cyst infection, or flank pain before the age of 35)

QUICK LINKS

Jynarque topic #21397

Note: This topic will be updated and the topic title renamed Jynarque and Tolvaptan on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

- A Mayo classification (height adjusted total kidney volume by CT or MRI and age) of class 1C, 1D, and 1E
- Documentation of average kidney length greater than 16.5 cm per ultrasonography, CT, or MRI

A copy of the member's medical records must be submitted and should sufficiently document:

- The information listed in the clinical coverage criteria.
- Details regarding previous medication use.
- The member's current treatment plan.

If the clinical criteria for Jynarque or tolvaptan are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Jynarque or tolvaptan may be approved for up to 365 days.

Renewal PA Requests

Requests for renewal must meet the clinical criteria for initial PA approval and have documentation to support that there has been a decrease in the member's kidney disease progression. In order to confirm the necessary adherence, the claims history and medical records will be reviewed for all renewal requests. A copy of the pertinent medical records must be included with the PA request.

Submitting PA Requests for Jynarque and Tolvaptan

PA requests for Jynarque and tolvaptan must be completed, signed, and dated by the prescriber. PA requests for Jynarque and tolvaptan must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should not submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Jynarque and tolvaptan may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Palynziq

Revised Clinical Criteria for Palynziq

ForwardHealth has revised the clinical criteria for Palynziq.

Clinical criteria that must be documented for approval of a PA request for Palynziq for members with phenylketonuria are **all** of the following:

- Palynziq must be prescribed in a dose and manner consistent with FDA-approved product labeling.
- The member has blood phenylalanine (Phe) levels greater than 600 micromole/L on existing management (for example, restriction of dietary Phe and protein intake).
- **At least one** of the following is true:
  - The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with sapropterin (Kuvan).
  - There is a clinically significant drug interaction between another drug(s) the member is taking and sapropterin (Kuvan).
  - The member has a medical condition(s) that prevents the use of sapropterin (Kuvan).
- Blood Phe levels will be obtained every four weeks until a maintenance dose is established. The drug dose should be titrated to the lowest effective dose. Once a maintenance dose is established, Phe levels will be monitored every six months.
- A copy of the member's medical records must be submitted and should document the following:
  - The medical record contains sufficient documentation to satisfy the previously listed clinical coverage criteria.
  - The medical record contains details regarding previous medication use.
  - The medical record describes the member's current treatment plan.

If the clinical criteria for Palynziq are met, initial PA requests may be approved for up to 183 days. Renewal PA requests for Palynziq may be approved for up to 365 days.

In addition to meeting the clinical criteria for initial PA request approval, renewal PA requests for Palynziq require the submission of medical records

QUICK LINKS

Palynziq topic #21200

Note: This topic will be updated on July 1, 2026.

(for example, chart notes, laboratory values) with the most recent results to demonstrate at least one of the following:

- The member has achieved at least a 20% reduction in blood Phe level from pretreatment baseline.
- The member has achieved a blood Phe level less than or equal to 600 micromole/L.

Submitting PA Requests for Palynziq

PA requests for Palynziq must be completed, signed, and dated by the prescriber. PA requests for Palynziq must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Palynziq may be submitted on the Portal, by fax, or by mail (but **not** STAT-PA system).

Wegovy Injection and Wegovy Tablets

Wegovy injection and Wegovy tablets require clinical PA.

Conditions for Which PA Requests for Use of Wegovy Injection or Wegovy Tablets Will Be Considered for Review

PA requests for Wegovy injection will only be approved for use in the identified clinical conditions:

- To reduce the risk of major adverse cardiovascular events (MACE) in overweight or obese adults with established cardiovascular disease
- To treat metabolic dysfunction-associated steatohepatitis (MASH) in adults
- To reduce excess body weight and maintain weight reduction long term in pediatric patients aged 12 years and older with obesity

PA requests for Wegovy tablets will only be approved to reduce the risk of MACE in overweight or obese adults with established cardiovascular disease.

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Prior Authorization/Drug Attachment topic #15937

Note: This topic will be updated on July 1, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

New Clinical Criteria for Wegovy Injection to Reduce Excess Body Weight and Maintain Weight Reduction Long Term in Pediatric Patients Aged 12 Years and Older With Obesity

ForwardHealth has established the clinical PA criteria for Wegovy injection to reduce excess body weight and maintain weight reduction long term in pediatric patients aged 12 years and older with obesity.

Clinical criteria that must be documented for approval of a PA request for Wegovy injection to reduce excess body weight and maintain weight reduction long term in pediatric patients aged 12 years and older with obesity are all of the following:

- Wegovy must be prescribed in a dose and manner consistent with FDA-approved product labeling.
- The member is 12–17 years of age.
- The member has a BMI greater than or equal to the 95th percentile standardized by age and gender.
- The member has agreed to follow a reduced-calorie diet and increase their physical activity.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Wegovy injection to reduce excess body weight and maintain weight reduction long term in pediatric patients aged 12 years and older with obesity. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- The member's current BMI (within the past three months)
- The member's current treatment plan

If the clinical criteria for Wegovy injection to reduce excess body weight and maintain weight reduction long term in pediatric patients aged 12 years and older with obesity are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests require documentation to support the member has had a reduction in BMI compared to their baseline prior to the initiation of Wegovy injection. A copy of the member's current medical records must be included with the PA request. Renewal PA requests for Wegovy injection to reduce excess body weight and maintain weight reduction long term in pediatric patients aged 12 years and older with obesity may be approved for up to 365 days.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Wegovy Injection and Wegovy Tablets to Reduce the Risk of Major Adverse Cardiovascular Events in Overweight or Obese Adults With Established Cardiovascular Disease

ForwardHealth has revised the clinical criteria for Wegovy injection and Wegovy tablets to reduce the risk of MACE in overweight or obese adults with established cardiovascular disease.

Clinical criteria that must be documented for approval of a PA request for Wegovy injection or Wegovy tablets to reduce the risk of MACE in overweight or obese adults with established cardiovascular disease are **all** of the following:

- Wegovy must be prescribed in a dose and manner consistent with the FDA-approved product labeling.
- The member has established cardiovascular disease, as evidenced by **one** of the following:
  - Prior myocardial infarction (heart attack)
  - Prior stroke
  - Peripheral arterial disease as evidenced by **one** of the following:
    - Intermittent claudication with an ABI of less than or equal to 0.9
    - Peripheral arterial revascularization procedure or amputation that is due to atherosclerotic disease
- The member has a BMI greater than or equal to 27.
- The member has agreed to follow a reduced-calorie diet and increase their physical activity.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Wegovy injection or Wegovy tablets to reduce the risk of MACE in overweight or obese adults with established cardiovascular disease. The supporting clinical information and medical records must document the following:

- Evidence that the member has established cardiovascular disease
- The member's current BMI (within the past three months)
- The member's current treatment plan

If clinical criteria for Wegovy injection or Wegovy tablets to reduce the risk of MACE in overweight or obese adults with established cardiovascular disease are met, initial PA requests may be approved for up to 183 days.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Renewal PA requests require documentation to support the member continues to follow a reduced-calorie diet and maintains physical activity. A copy of the member's current medical records must be included with the PA request. Renewal PA requests for Wegovy injection or Wegovy tablets to reduce the risk of MACE in overweight or obese adults with established cardiovascular disease may be approved for up to 365 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria Wegovy Injection to Treat Metabolic Dysfunction-Associated Steatohepatitis

Clinical criteria that must be documented for approval of a PA request for Wegovy injection to treat MASH are **all** of the following:

- Wegovy must be prescribed in a dose and manner consistent with FDA-approved product labeling.
- The member has been diagnosed with noncirrhotic MASH, formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) by a biopsy or noninvasive tests (such as FibroScan or magnetic resonance enterography [MRE] + MRI-proton density fat fraction [PDFF]).
- The member has agreed to follow a reduced-calorie diet and increase their physical activity.
- The prescription is written by a liver specialist physician such as a gastroenterologist or hepatologist.
- The prescriber will monitor for elevations in liver tests and development of liver-related adverse reactions.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Wegovy injection to treat MASH. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Wegovy injection to treat MASH are met, initial PA requests may be approved for up to 183 days.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Initial Renewal PA Request

Initial renewal PA requests require documentation to support that the member is responding adequately to treatment (as documented in laboratory tests). A copy of the member's current medical records must be included with the PA request. Initial renewal PA requests for Wegovy injection to treat MASH may be approved for up to 183 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Subsequent Renewal PA Requests

Subsequent renewal PA requests require documentation to support that the member is responding adequately to treatment (as documented in laboratory tests and a biopsy or noninvasive tests [such as FibroScan or MRE + MRI-PDFF]) and has resolution of steatohepatitis without worsening of fibrosis or at least one stage improvement in fibrosis without worsening of steatohepatitis. A copy of the member's current medical records must be included with the PA request. Subsequent renewal PA requests for Wegovy injection to treat MASH may be approved for up to 365 days.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Wegovy Injection and Wegovy Tablets

PA requests for Wegovy injection or Wegovy tablets must be completed, signed, and dated by the prescriber. PA requests for Wegovy injection or Wegovy tablets must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of Wegovy injection or Wegovy tablets must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

QUICK LINKS

Forms page

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

PA requests for Wegovy injection or Wegovy tablets may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Copay for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copay to a brand name drug when a drug that previously required BMN PA becomes a preferred drug on the PDL, and the available generic equivalents are non-preferred drugs.

This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and not yet cost-effective when compared to brand pricing.

For drugs included in this policy, ForwardHealth will automatically apply the generic copay when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate a National Council for Prescription Drug Program Dispense as Written/Product Selection code on claims to ensure the generic copay deduction.

Refer to Attachment C for the Copay for Brand Name Drugs Preferred Over Generic Drugs table for the most current list of drugs for which this copay policy applies. This information is also available on the Preferred Drug List Quick Reference data table.

Expedited Emergency Supply Request Drugs Data Table

As a result of the changes made during the May 2026 PDL review, the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page will be updated effective July 1, 2026.

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § DHS 106.02(9). Providers are required to produce or submit documentation, or both, to the Wisconsin Department of Health Services (DHS) upon request. Per Wis. Stat. § 49.45(3)(f), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

QUICK LINKS

Amounts topic #1927

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Information Regarding Managed Care Organizations

This Update applies to Family Care, Family Care Partnership, BadgerCare Plus, and SSI Medicaid managed care program members because pharmacy services for members of these programs are provided on a fee-for-service basis. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) are provided by the member's managed care organization.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

This Update was issued on 06/19/2026 and information contained in this Update was incorporated into the Online Handbook on 07/01/2026.

ATTACHMENT A
Changes to Preferred or Non-Preferred Status of Drugs on the Preferred Drug List

This table lists the drugs that changed their preferred or non-preferred status as a result of the May 2026 Preferred Drug List (PDL) review. Unless otherwise noted, the updated statuses are effective July 1, 2026. Drugs that have not been previously reviewed by the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee are marked with footnote ([1]). Non-preferred drugs in a PDL drug class that are not represented on the PDL Quick Reference are marked with footnote ([2]). The current Preferred Drug List Quick Reference data table can be referenced on the Pharmacy Resources page of the ForwardHealth Portal.

DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JULY 1, 2026, UNLESS OTHERWISE NOTED
Acne Agents, Topical	sulfacetamide sodium susp[2]	Non-Preferred
	tretinoin (Atralin)[2]	Non-Preferred
Analgesics, Opioids Short-Acting	hydrocodone/apap solution[1]	Non-Preferred
Angiotensin Modulators, ARBs and DRIs	telmisartan	Preferred
	telmisartan/HCTZ	Preferred
	Arbli suspension[1]	Non-Preferred
Antibiotics, Beta-Lactam	Pivya tablet[1]	Non-Preferred
Antibiotics, GI	fidaxomicin tablet (Gen-Dificid tablet)[1]	Preferred
Antibiotics, Macrolides/ Ketolides	erythromycin 400 mg suspension	Non-Preferred
	erythromycin tablet	Preferred
Antibiotics, Other	Blujepa[1]	Non-Preferred
	Orlynvah tablet[1]	Non-Preferred
Antibiotics, Vaginal	Xaciato 2% gel	Preferred

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DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JULY 1, 2026, UNLESS OTHERWISE NOTED
Anticoagulants	rivaroxaban 2.5 mg tablet (Gen-Xarelto 2.5 mg tablet)[1]	Preferred
	rivaroxaban suspension (Gen-Xarelto suspension)[1]	Non-Preferred
	Eliquis sprinkle[1]	Preferred
	Eliquis tablet for suspension[1]	Preferred
	Xarelto suspension	Non-Preferred
Antiemetics	aprepitant capsules	Non-Preferred
	aprepitant pack	Non-Preferred
	trimethobenzamide capsule	Non-Preferred
Antiemetics/Antivertigo	Transderm-Scop	Non-Preferred
Antifungals, Topical	econazole nitrate foam[1]	Non-Preferred
Antiparasitics, Topical	spinosad	Preferred
	Pruradik lotion[1]	Non-Preferred
BPH Agents, Andrenergic	silodosin	Preferred
	Tezruly solution[1]	Non-Preferred
Beta Blockers	Lopressor solution[1]	Non-Preferred
Bladder Relaxant Preparations	darifenacin ER	Preferred
	trospium	Preferred
	Oxytrol OTC[1]	Preferred
Bone Resorption Suppression	Bonsity[1]	Non-Preferred
Calcium Channel Blocking Agents	felodipine ER	Preferred
	Cardamyst nasal spray[1]	Non-Preferred
	Sdamlo solution[1]	Non-Preferred
GI Motility, Chronic – Constipation	prucalopride (Gen-Motegrity)	Preferred
Headache Agents, Other	Brekiya[1]	Non-Preferred
Headache Agents, Triptans Non-Injectable	Symbravo tablet[1]	Non-Preferred
	Zomig nasal spray	Non-Preferred
H. Pylori	Talicia	Non-Preferred

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DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JULY 1, 2026, UNLESS OTHERWISE NOTED
HIV/AIDS	emtricit-rilp-tenof[1]	Non-Preferred
	maraviroc	Preferred
	Prezista tablet	Non-Preferred
	Selzentry tablet	Non-Preferred
	Yeztugo tablet[1]	Preferred
Hypoglycemics, DPP-4 Inhibitors	sitagliptin/metformin ER tablets (Gen-Zituvimet XR tablet)[1]	Non-Preferred
	Brynovin solution[1]	Non-Preferred
	Janumet XR	Non-Preferred
Hypoglycemics, GLP- 1	exenatide (Gen-Byetta)[1]	Non-Preferred
	Mounjaro pen	Preferred
Hypoglycemics, Insulins	insulin aspart U-100 cartridge/pen/vial (Gen-Novolog)	Non-Preferred
	insulin aspart/protamine pen/vial (Gen-Novolog Mix)	Non-Preferred
	Humalog Mix vial	Non-Preferred
	Kirsty U-100 pen and vial[1]	Non-Preferred
	Merilog solostar U-100 pen[1]	Non-Preferred
	Merilog U-100 vial[1]	Non-Preferred
	Novolog Mix	Non-Preferred
	Novolog U-100 cartridge/pen/vial	Non-Preferred
Hypoglycemics, Insulins Long-Acting	Levemir	Non-Preferred
Hypoglycemics, Sulfonylureas	glipizide/metformin	Preferred
Lipotropics, Other	Redemplo[1]	Non-Preferred
MS Agents	cladribine tablet (Gen-Mavenclad)[1]	Non-Preferred
Opioid Dependency Agents-Buprenorphine	buprenorphine tabs (without naloxone)	Preferred
Opioid Dependency Agents-Rescue Agent	Opvee spray	Non-Preferred
	Zurnai[1]	Non-Preferred
Prenatal Vitamins	one natal RX[2]	Non-Preferred
	Folatexcel[2]	Non-Preferred

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DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JULY 1, 2026, UNLESS OTHERWISE NOTED
Proton Pump Inhibitors	rabeprazole	Preferred
	Dexilant DR	Non-Preferred
	Nexium DR packet	Non-Preferred
Pulmonary Arterial Hypertension	bosentan tab for suspension (Gen-Tracleer tab for suspension)[1]	Non-Preferred
	Yutrepia inhalation[1]	Non-Preferred
Skeletal Muscle Relaxants	chlorzoxazone 500 mg tablet	Non-Preferred
	dantrolene sodium	Non-Preferred
	Tonmya[1]	Non-Preferred
Weight Management Agents	Foundayo[1]	Preferred
	Zepbound[1]	Preferred

[1] The drug was not previously reviewed by the Wisconsin Medicaid Pharmacy PA Advisory Committee. For more information, providers should refer to the Drug Status Changes on the Preferred Drug List section of this ForwardHealth Update.

[2] Non-preferred drugs in this PDL drug class are not represented on the PDL Quick Reference. Refer to the Drug Search Tool for a list of the non-preferred drugs in this drug class.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

ATTACHMENT B
Changes to Pharmacy-Related Prior Authorization Forms and Instructions

This table lists the pharmacy-related prior authorization (PA) forms and instructions that have been revised, revised and renamed, or discontinued as the result of the May 2026 Preferred Drug List review or other pharmacy policy changes. Providers should refer to the Forms page of the ForwardHealth Portal for current copies of these forms and instructions. Effective July 1, 2026, the previous versions of these forms and instructions will be moved to the Archived Pharmacy-Related Forms and Instructions page. For more information regarding clinical criteria or PA request submission options, refer to the applicable section in this ForwardHealth Update.

FORM NAME	FORM NUMBER	REVISED, REVISED AND RENAMED, OR DISCONTINUED	EFFECTIVE DATE
Prior Authorization Drug Attachment for Anti-Obesity Drugs	F-00163	**Revised and Renamed:** Prior Authorization Drug Attachment for Weight Management Agents	07/2026
Instructions	F-00163A	Revised and Renamed	07/2026
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis	F-01950	Revised	07/2026
Instructions	F-01950A	Revised	07/2026
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis	F-11306	Revised	07/2026
Instructions	F-11306A	Revised	07/2026

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

FORM NAME	FORM NUMBER	REVISED, REVISED AND RENAMED, OR DISCONTINUED	EFFECTIVE DATE
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis	F-01951	Revised	07/2026
Instructions	F-01951A	Revised	07/2026
Prior Authorization Drug Attachment for Voquezna Tablets	F-03384	Revised	07/2026
Instructions	F-03384A	Revised	07/2026
Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents – Buprenorphine	F-00081	Discontinued	07/2026
Instructions	F-00081A	Discontinued	07/2026
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules, Suspensions, and Non-Orally Disintegrating Tablets	F-11078	**Revised and Renamed:** Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitors (PPIs)	07/2026
Instructions	F-11078A	Revised and Renamed	07/2026
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets	F-00433	Discontinued	07/2026
Instructions	F-00433A	Discontinued	07/2026

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ATTACHMENT C
Copay for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copay to a brand name drug when a drug that previously required brand medically necessary prior authorization becomes a preferred drug on the Preferred Drug List and the available generic equivalents are non-preferred drugs. This table lists the drugs with generic copay. The Preferred Drug List Quick Reference data table, which also includes the current Brand Name Drugs With Generic Copay table, is available on the Pharmacy Resources page of the ForwardHealth Portal.

DRUG CLASS	DRUG NAME	EFFECTIVE DATE
Anticonvulsants	Carbatrol ER	01/01/2021
	Depakote sprinkle	01/01/2021
	Tegretol suspension	01/01/2016
	Tegretol tablet	01/01/2016
	Tegretol XR	01/01/2021
Bone Resorption Suppression	Forteo	07/01/2022
Bronchodilators, Beta Agonists	Ventolin HFA	01/01/2023
HIV/AIDS	Intelence	07/01/2023
	Selzentry solution	07/01/2026
	Symfi	07/01/2023
Hypoglycemics, Insulins	Humalog Jr Kwikpen	05/01/2020
	Humalog Mix Pen	07/01/2026
	Humalog U-100 cartridge/kwikpen/vial	07/01/2019
Hypoglycemics, Insulins Long-Acting	Lantus	07/01/2022
Ophthalmics, Antibiotic-Steroid Combinations	Tobradex suspension	01/01/2012
Ophthalmics, Glaucoma-Other	Alphagan P 0.15%	01/01/2012
Ophthalmics, Glaucoma-Prostaglandins	Xalatan	01/01/2023
Opioid Dependency Agents—Buprenorphine	Suboxone film	07/01/2020
Stimulants	Concerta	01/01/2018
	Vyvanse capsule	01/01/2024

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