



CONTAINS CONFIDENTIAL PATIENT INFORMATION

GLP-1 Agonist/Basal Insulin Combinations Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at 1-844-512-9004

Provider Help Desk 1-800-454-3730

1. Patient information

2. Physician information

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

_____	_____	_____	Specify: _____
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7. Diagnosis: \_\_\_\_\_

8. Approval criteria: CHECK ALL BOXES THAT APPLY

Note: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met:

- 1) A diagnosis of Type 2 Diabetes Mellitus; and
- 2) Patient is 18 years of age or older; and
- 3) The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated; and
- 4) Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and
- 5) Will not be used concurrently with prandial insulin; and
- 6) Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and
- 7) Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of:
  - a) Soliqua below 15 units or over 60 units, or
  - b) Xultophy persistently below 16 units or over 50 units.

Most recent HgbA1C level: \_\_\_\_\_ Date this level was obtained: \_\_\_\_\_



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Patient name: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

Metformin trial: Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_ Trial dose: \_\_\_\_\_

Reason for failure: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

Preferred GLP-1 Receptor Agonist Trial: Drug name/dose: \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_ Reason for failure: \_\_\_\_\_

Preferred Long-Acting Insulin Trial: Drug name/dose: \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_ Reason for failure: \_\_\_\_\_

Clinical rationale as to why patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently: \_\_\_\_\_

Is prandial insulin being used concurrently?

Yes  No

Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of:

Soliqua – below 15 units or over 60 units  Yes  No

Xultophy - persistently below 16 units or over 50 units  Yes  No

Attach lab results and other documentation as necessary.

Patient name: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

9. Physician signature

\_\_\_\_\_  
Prescriber or authorized signature

\_\_\_\_\_  
Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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