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Insulin Prefilled Pens Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 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: _____

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 (PA) is required for prefilled insulin pens as designated on the *Preferred Drug List* (*PDL*). For prefilled insulin pens requiring PA where the requested insulin is available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin (not applicable for pediatric patients); and 2) there is no caregiver available to provide assistance; and 3) patient does not reside in a long-term care facility; and 4) for requests for nonpreferred prefilled pens, patient has documentation of a previous trial and therapy failure with a preferred prefilled insulin pen within the same class (e.g., rapid, regular or basal). For prefilled insulin pens requiring PA where the requested insulin is not available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) Preferred prefilled insulin pens — Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e., rapid, regular, or basal) or clinical rationale as to why the patient cannot use a preferred insulin agent; and 2) Nonpreferred prefilled insulin pens — Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same

class (i.e. rapid, regular or basal); and 3) Requests for Toujeo will require clinical rationale as to why the patient cannot use Lantus and patient must be using a minimum of 100 units of Lantus per day.

Preferred (no PA required)

☐ Humulin R U-500 Kwikpen ☐ Lantus SoloSTAR ☐ Levemir FlexTouch

☐ NovoLog FlexPen/Pen Fill ☐ Novolog Mix FlexPen ☐ Insulin Lispro KwikPen

Nonpreferred (available in vial)

☐ Admelog SoloSTAR ☐ Humulin 70/30 KwikPen

☐ Apidra SoloSTAR ☐ Tresiba Flextouch

☐ Fiasp FlexTouch

☐ Humalog Kwik Pen

☐ Humulog Mix 50/50 Pen

☐ Humulin Mix 75/25 Pen

☐ Humulin N KwikPen

Nonpreferred (not available in vial)

☐ Basaglar KwikPen

☐ Toujeo SoloStar

Number of units: _____ **How often:** _____ **Number of cartridges/pens/pen fills (circle requested item):** _____

☐ **Requests for insulin agents available in a vial:**

What visual or physical conditions limit the patient's ability to prepare their own syringes (adult patients only)?

_____

Does the patient lack capable assistance residing with them? ☐ Yes ☐ No

Does the patient reside in a long-term care facility? ☐ Yes ☐ No

Requests for a nonpreferred prefilled insulin pen, document preferred prefilled insulin pen trial within the same class:

Drug name and dosage instructions: _____ Trial start date: _____

Trial end date: _____

Failure reasons: _____

_____

☐ **Requests for insulin agents not available in a vial**

Document preferred insulin trial in same class as requested agent:

Drug name and dosage instructions: _____

Trial start date: _____ Trial end date: _____

Failure reasons: _____

_____

Toujeo:

Patient's current daily Lantus dose: _____

Clinical rationale as to why patient cannot use Lantus: _____

_____

Attach lab results and other documentation as necessary.

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.