

Request for Prior Authorization ANTI-DIABETIC NON-INSULIN AGENTS

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at **844-512-9004**.

Provider Help Desk: **800-454-3730**

1. Patient information

Patient name: _____
 Patient ID #: _____
 Patient DOB: _____
 Date of Rx: _____
 Patient phone #: _____
 Patient email address: _____

2. Physician information

Prescribing physician: _____
 Physician address: _____
 Physician phone #: _____
 Physician fax #: _____
 Physician specialty: _____
 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 (PA) is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2) For the treatment of Type 2 Diabetes Mellitus, the patient has not achieved HgbA1C goals after a minimum three-month trial with metformin at a maximally tolerated dose. 3) Requests for non-preferred anti-diabetic, non-insulin agents subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination, a preferred GLP-1 RA, and a preferred SGLT2 Inhibitor at maximally tolerated doses. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Requests for weight loss are not a covered diagnosis of use and will be denied. Initial authorizations will be approved for six months. Additional PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).

Preferred DPP-4 Inhibitors and Combinations

Non- Preferred DPP-4 Inhibitors and Combinations

(PA Required)		<input type="checkbox"/> Alogliptin	<input type="checkbox"/> Jentadueto XR	<input type="checkbox"/> Onglyza
<input type="checkbox"/> Janumet	<input type="checkbox"/> Jentadueto	<input type="checkbox"/> Alogliptin-Metformin	<input type="checkbox"/> Kazano	<input type="checkbox"/> Oseni
<input type="checkbox"/> Janumet XR	<input type="checkbox"/> Tradjenta	<input type="checkbox"/> Alogliptin-Pioglitazone	<input type="checkbox"/> Kombiglyze XR	<input type="checkbox"/> Trijardy XR
<input type="checkbox"/> Januvia		<input type="checkbox"/> Glyxambi	<input type="checkbox"/> Nesina	
Preferred GLP-1 RAs (PA required)		Non-Preferred GLP-1 RAs and Combinations		
<input type="checkbox"/> Bydureon	<input type="checkbox"/> Trulicity	<input type="checkbox"/> Adlyxin	<input type="checkbox"/> Byetta	<input type="checkbox"/> Rybelsus
<input type="checkbox"/> Ozempic	<input type="checkbox"/> Victoza	<input type="checkbox"/> Bydureon BCise	<input type="checkbox"/> Mounjaro	
Preferred SGLT2 Inhibitors and Combinations (No PA Required)		Non-Preferred SGLT2 Inhibitors and Combinations		
<input type="checkbox"/> Farxiga	<input type="checkbox"/> Jardiance	<input type="checkbox"/> Invokamet XR	<input type="checkbox"/> Segluromet	<input type="checkbox"/> Steglujan
<input type="checkbox"/> Invokamet	<input type="checkbox"/> Synjardy	<input type="checkbox"/> Qtern	<input type="checkbox"/> Steglatro	<input type="checkbox"/> Synjardy XR
<input type="checkbox"/> Invokana	<input type="checkbox"/> Xigduo XR			

Type 2 Diabetes Mellitus

Metformin Trial: Trial start date: _____ Trial end date: _____ Trial dose: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

Most recent HgbA1C Level: _____ **Date this level was obtained:** _____

Requests for Non-Preferred Drugs:

Preferred DPP- 4 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Preferred GLP-1 RA Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Preferred SGLT2 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Other diagnosis: _____

Trial of preferred drug in the same class: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Failure reason:

Renewals

Document continued improvement in symptoms:

9. Physician signature

Prescriber or authorized signature

***MUST MATCH PRESCRIBER LISTED ABOVE**

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.

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*