Prior Authorization Request Form for Hypoglycemic Agents

(Amylin Analog, SGLT2 Inhibitors, GLP-1 Receptor Agonists, DPP-4 Inhibitors, TZDs)

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Hypoglycemic Agent? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

Quantity Limit:

- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

Therapeutic Duplication:

If concurrently prescribed a therapeutic duplicate (i.e. a hypoglycemic agent from same class different from the agent being requested):

- ☐ Is being transitioned from one hypoglycemic agent to another with the intent of discontinuing one of the medications
- ☐ Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

Sodium-Glucose Co-Transporter (SGLT2) Inhibitors, Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists or Dipeptidyl Peptidase-4 (DPP-4) Inhibitors, Thiazolidinediones (TZD):

- ☐ Documented history of one of the following:
  - ☐ Failure to achieve glycemic control as evident by member's HbA1c value using maximum tolerated doses of Metformin
  - ☐ Contraindication or intolerance to Metformin
  - ☐ Member requires initial dual therapy with metformin based on HbA1c as defined by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology
- ☐ Does the member have cardiovascular disease (CVD), heart failure (HF), or chronic kidney disease (CKD) or at least 2 risk factors as identified by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology?:_____

AMYLIN ANALOG:

- ☐ Failed to achieve adequate glycemic control as evident by the HbA1c value despite compliance with optimal insulin therapy
- ☐ Requested amylin analog will be prescribed in combination with insulin

RENEWAL REQUESTS:

☐ Documentation of most recent HbA1c:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)