envolve Pharmacy Solutions | pa health & wellness

# Prior Authorization Request Form for Hypoglycemic Agents

**FAX this completed form to (877) 386-4695**

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

| I. PROVIDER INFORMATION | II. MEMBER INFORMATION |
|---|---|
| Prescriber Name: | Member Name: |
| Prescriber Specialty: | Identification #: |
| Office Contact Name: | Group #: |
| Group 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: |
|---|---|---|

Envolve Pharmacy Solutions 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.)