Prior Authorization Request Form for Hypoglycemics, Incretin Mimetics/Enhancers

FAX this completed form to (844) 205-3386
OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:

☐Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the member's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.)*

☐**Attestation from the prescriber:**

☐The member was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐**The member is 18 years of age or older:**

Pre-treatment weight: _____ Pre-treatment BMI: _____

☐Has a BMI greater than or equal to 30 kg/m^2

☐Has a BMI greater than or equal 27 kg/m^2 and less than 30 kg/m^2 and at least one of the following weight-related comorbidities:

☐dyslipidemia
☐hypertension
☐metabolic syndrome
☐other (list): _____
☐obstructive sleep apnea
☐prediabetes
☐type 2 diabetes
_____

☐Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for member's

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ethnicity, etc. and has at least one of the following weight-related comorbidities:

- ☐ dyslipidemia
- ☐ hypertension
- ☐ metabolic syndrome
- ☐ other (list): _____
- ☐ obstructive sleep apnea
- ☐ prediabetes
- ☐ type 2 diabetes
- _____

☐ **The member is less than 18 years of age:**

Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

☐ Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

2. For the treatment of ALL OTHER diagnoses:

☐ **Request is for a non-preferred GLP-1 receptor agonist:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists that are approved or medically accepted for the member's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists.)*

☐ **Request is for a non-preferred DPP-4 inhibitor:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors that are approved or medically accepted for the member's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.)*

☐ **Request is for non-preferred Symlin (pramlintide)**

RENEWAL requests

☐ **For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the member's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.)*

☐ The dose of the requested medication is currently being titrated

☐ The member is experiencing clinical benefit with the requested medication

☐ **Attestation from the prescriber:**

☐ The member was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐ **The member is 18 years of age or older:**

Pre-treatment weight: _____ Current weight: _____

☐ **The member is less than 18 years of age:**

Pre-treatment BMI: _____ Current BMI: _____

Pre-treatment BMI z-score: _____ Current BMI z-score: _____

☐ **The member is being treated for a diagnosis OTHER THAN OBESITY.**

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO (844) 205-3386

Prescriber Signature:	**Date**:

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PA 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.