pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HYPOGLYCEMICS, INCRETIN MIMETICS (GLP-1 receptor agonists) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hypoglycemics, Incretin Mimetics/Enhancers** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested ***(clinical prior authorization required)*:**	☐Bydureon 2 mg pen ☐Bydureon 2 mg vial	☐Victoza 6 mg/ml 2-pen package (2 x 3 ml pens) ☐Victoza 6 mg/ml 3-pen package (3 x 3 ml pens)	
Non-preferred medication requested:	☐Adlyxin 10-20 mcg starter pack ☐Adlyxin 20 mcg maintenance pack ☐Bydureon BCise 2 mg auto-injector ☐Byetta 1.2 ml (5 mcg/dose) pen	☐Byetta 2.4 ml (10 mcg/dose) pen ☐Ozempic 0.25 mg-0.5 mg pen ☐Ozempic 1 mg pen ☐Tanzeum 30 mg/0.5 ml pen	☐Tanzeum 50 mg/0.5 ml pen ☐Trulicity 0.75 mg/0.5 ml pen ☐Trulicity 1.5 mg/0.5 ml pen ☐_____

For Symlin requests, please use the "Symlin Form."

Dose:	Frequency of injection:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

1. Does the beneficiary have a diagnosis of type 2 diabetes?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
2. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of maximum tolerated doses of **metformin**?	☐Yes ☐No *Submit documentation showing trial and failure of, or contraindication or intolerance to, metformin (including result of a recent HbA1c).*
3. ***Requests for NON-PREFERRED agents only:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Incretin Mimetic Agents? *Check all that apply*. ☐Bydureon pen injector/vial ☐Symlin ☐Victoza	☐Yes ☐No *Submit documentation of medication regimens tried and treatment results, contraindications, and/or intolerances.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: