

HYPOGLYCEMICS, INCRETIN MIMETICS PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits for **Hypoglycemics, Incretin Mimetics/Enhancers** and **Quantity Limits/Daily Dose Limits** are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA# _____	_____	Specialty: _____		
Name of office contact: _____			State license #: _____		
Contact's phone number: _____			NPI: _____		MA Provider ID#: _____
LTC facility contact/phone: _____			Street address: _____		
RECIPIENT INFORMATION			Suite #: _____		
Recipient Name: _____			City/state/zip: _____		
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

CLINICAL INFORMATION

Medication requested	Preferred:	<input type="checkbox"/> Bydureon 2 mg vial	<input type="checkbox"/> Bydureon 2 mg pen
		<input type="checkbox"/> Byetta 1.2 ml (5 mcg/dose) pen	<input type="checkbox"/> Byetta 2.4 ml (10 mcg/dose) pen
	Non-Preferred:	<input type="checkbox"/> Victoza 6 mg/ml 2-pen package (2 x 3 ml pens)	<input type="checkbox"/> Victoza 6 mg/ml 3-pen package (3 x 3 ml pens)
		<input type="checkbox"/> Tanzeum 30 mg/0.5 ml pen	<input type="checkbox"/> Tanzeum 50 mg/0.5 ml pen
		<input type="checkbox"/> Trulicity 0.75 mg/0.5 ml pen	<input type="checkbox"/> Trulicity 1.5 mg/0.5 ml pen

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

Dose: _____	Frequency of injection: _____	Requested duration: _____
Diagnosis (<i>submit documentation</i>): _____		DX code (<i>required</i>): _____

Section A: Initial requests

1. Record the Recipient's baseline (before starting the requested medication) hemoglobin A1c value. Baseline (before starting medication): _____ % Date: _____	<i>Submit documentation of lab result.</i>
2. Did the Recipient fail to achieve glycemic control with <u>maximum tolerated doses</u> of metformin in combination with <u>maximum tolerated doses</u> of a sulfonylurea, or does the Recipient have a contraindication or intolerance of metformin and/or sulfonylureas?	<input type="checkbox"/> Yes <i>Submit documentation of medication regimens tried and treatment results, contraindications, and/or intolerances.</i> <input type="checkbox"/> No
3. Do any of the following apply to the Recipient? <i>Check all that apply.</i>	<input type="checkbox"/> history or current symptoms of pancreatitis <input type="checkbox"/> personal or family history of Medullary Thyroid Carcinoma (MTC) <input type="checkbox"/> history or current symptoms of gastroparesis <input type="checkbox"/> diagnosis of Multiple Endocrine Neoplasia Syndrome Type-2 (MEN-2)
4. <i>For Byetta and Bydureon requests</i> , record Recipient's creatinine clearance: _____ ml/min.	<i>Submit documentation of recent lab result.</i>
5. <i>For non-preferred requests [indicated in above list]</i> , does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred Incretin Mimetic Agents? <i>Check all that apply.</i>	<input type="checkbox"/> Yes <i>Submit documentation of medication regimens tried and treatment results, contraindications, and/or intolerances.</i> <input type="checkbox"/> No

Section B: Renewal requests

1. Record the following hemoglobin A1c (HbA1c) values for the Recipient. Baseline (before starting medication): _____ % Date: _____ Most recent (since starting medication): _____ % Date: _____	<i>Submit documentation of lab results.</i>
2. Do any of the items in question 3 above [Section A: Initial Requests] apply to the Recipient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
3. <i>For Byetta and Bydureon requests</i> , record Recipient's creatinine clearance: _____ ml/min.	<i>Submit documentation of recent lab results.</i>

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

Prescriber Signature: _____	Date: _____
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