

## HYPOGLYCEMICS, MEGLITINIDES PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Meglitinides, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Hypoglycemics, Meglitinides** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

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

### CLINICAL INFORMATION

|   |                  |  |  |   |   |   |
|---|------------------|--|--|---|---|---|
| <b>Non-preferred medication requested:</b>  |                  |  |  | <input type="checkbox"/> nateglinide tablet | <input type="checkbox"/> Prandin tablet   | <input type="checkbox"/> Starlix tablet |
|   |                  |  |  | <input type="checkbox"/> Prandimet tablet   | <input type="checkbox"/> repaglinide/metformin tablet   |   |
| Strength:   | Dose/directions: |  |  | Quantity:                                   | Refills:  |   |
| Diagnosis ( <i>submit documentation</i> ):  |                  |  |  |   | DX code ( <i>required</i> ):  |   |
| 1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Meglitinide, <b>repaglinide tablet</b> ? |                  |  |  |   | <input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agent tried and treatment outcomes, including contraindications or intolerances</u><br><br><input type="checkbox"/> No |   |

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

|                              |              |
|------------------------------|--------------|
| <b>Prescriber Signature:</b> | <b>Date:</b> |
|------------------------------|--------------|

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