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, INSULIN & RELATED AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hypoglycemics, Insulin and Related Agents** 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

Non-preferred medication requested*: *(*NOTE: For Afrezza requests, please call the Pharmacy Services help desk.)*

☐Admelog Solostar pen	☐Fiasp vial	☐Humalog Mix 75/25 Kwikpen	☐Toujeo U-300 Solostar pen
☐Admelog vial	☐Humalog U-100 cartridge	☐Humulin 70/30 Kwikpen	☐Toujeo Max U-300 Solostar pen
☐Apidra Solostar pen	☐Humalog U-100 Kwikpen	☐Humulin N Kwikpen	☐Tresiba U-100 Flextouch pen
☐Apidra vial	☐Humalog U-200 Kwikpen	☐Novolin 70/30 vial	☐Tresiba U-200 Flextouch pen
☐Basaglar Kwikpen	☐Humalog Junior U-100 Kwikpen	☐Novolin N vial	☐Xultophy
☐Fiasp Flextouch pen	☐Humalog Mix 50/50 Kwikpen	☐Soliqua	☐_____

Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Requests for a non-preferred insulin-only agent	
1. Does the beneficiary have a history of trial and failure of, or contraindication or intolerance to, the preferred Hypoglycemics, Insulins? *Check all that apply.* ☐Humalog U-100 vial ☐Humulin R U-500 Kwikpen or vial ☐Humalog Mix 50-50 vial ☐Lantus vial or Solostar pen ☐Humalog Mix 75-25 vial ☐Levemir vial or Flextouch pen ☐Humulin 70/30 vial ☐Novolin R vial ☐Humulin N vial ☐NovoLog cartridge, Flexpen, or vial ☐Humulin R U-100 vial ☐NovoLog Mix 70/30 Flexpen or vial	☐Yes ☐No *Submit documentation of insulins tried and treatment outcomes (including HbA1c results) or contraindication or intolerance.*
Requests for a combination agent containing insulin and a GLP-1 receptor agonist (e.g., Soliqua, Xultophy)	
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 of, or contraindication or intolerance to, maximum tolerated doses of **metformin?**	☐Yes ☐No *Submit documentation of treatment regimen tried and HbA1c results or contraindication or intolerance.*
3. Did the beneficiary fail to achieve glycemic goals with **basal insulin** (e.g., Lantus, Levemir) and/or a **GLP-1 receptor agonist** (e.g., Bydureon, Victoza)?	☐Yes ☐No *Submit documentation of treatment regimen tried and HbA1c results.*

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

Prescriber Signature:	**Date**: