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 ENHANCERS (DPP-4 inhibitors) 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 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):**	☐Janumet tablet ☐Januvia tablet	☐Jentadueto tablet ☐Jentadueto XR tablet	☐Tradjenta tablet
Non-preferred medication requested:	☐alogliptin tablet ☐alogliptin/metformin tablet ☐alogliptin/pioglitazone tablet ☐_____	☐Janumet XR tablet ☐Kazano tablet ☐Kombiglyze XR tablet	☐Nesina tablet ☐Onglyza tablet ☐Oseni tablet

Strength:	Dose/directions:	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 of the preferred Incretin Enhancers (DPP-4 Inhibitors)? *Check all that apply.* ☐Janumet tablet ☐Jentadueto tablet ☐Tradjenta tablet ☐Januvia tablet ☐Jentadueto XR tablet	☐Yes ☐No *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

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

Prescriber Signature:	**Date**: