

HYPOGLYCEMICS, TZD
PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for these agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter - Hypoglycemics, TZD (accessible at: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm>). These agents are also subject to quantity limits – if the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: <http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information

For Additional Information: Coordinator Name: _____ PA#: _____

Number of Pages in this Request: _____ Office Contact Name: _____ & Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

NPI#: _____ OR MA Provider ID#: _____ State License#: _____

Prescriber Address: _____ Suite #: _____

City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____

MEDICAL INFORMATION

Drug Requested:

Preferred Agents: pioglitazone

Non-Preferred Agents: Actos Actoplus Met Actoplus Met XR Avandamet Avandaryl
 Avandia Duetact pioglitazone/glimepiride pioglitazone/metformin

Strength: _____ **Directions:** _____ **Quantity:** _____ **Refills:** _____

Diagnosis: _____ **Diagnosis Code:** _____ (Required)

Non-Preferred Request:

1. Has the Recipient tried the preferred agent: pioglitazone? Yes (submit documentation) No
2. Does the Recipient have a contraindication or intolerance to pioglitazone? Yes (submit documentation) No

All Initial Requests:

1. Hemoglobin A1c Level: _____ Date Taken: _____ (submit documentation)
2. Has the Recipient failed to achieve glycemic control with maximum tolerated doses of metformin in combination with maximum tolerated doses of a sulfonylurea? Yes (submit documentation) No
3. Does the Recipient have a contraindication or intolerance to maximum tolerated doses of metformin and a sulfonylurea?
 Yes (submit documentation) No
4. Does the Recipient have either of the following medical conditions (check any that apply & submit documentation):
 Bladder cancer (past or present) Heart failure
5. Does the Recipient have results of a recent serum creatinine (SCr) level? Yes (submit documentation) No

All Renewal Requests:

1. When did the Recipient start therapy? Date: _____ Baseline Hemoglobin A1c Level: _____
2. What is the Recipient's most recent Hemoglobin A1c Level? _____ Date Taken: _____ (submit documentation)
3. Does the Recipient have either of the following medical conditions (check any that apply & submit documentation):
 Bladder cancer (past or present) Heart failure
4. Does the Recipient have results of a recent serum creatinine (SCr) level? Yes (submit documentation) No

PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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