

SOLIQUA and XULTOPHY (GLP-1 receptor agonist/insulin combinations) 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 <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:		
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	<input type="checkbox"/> Soliqua	<input type="checkbox"/> Xultophy	<input type="checkbox"/> _____
Directions:	Quantity:	Refills:	
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):		
Does the beneficiary have a diagnosis of type 2 diabetes?	<input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.</i>		
Does the beneficiary have a history of trial and failure of, or contraindication or intolerance to, maximum tolerated doses of metformin ?	<input type="checkbox"/> Yes <i>Submit documentation of treatment regimen tried and HbA1c results or contraindication or intolerance.</i> <input type="checkbox"/> No		
Did the beneficiary fail to achieve glycemic goals with basal insulin (e.g., Lantus, Levemir) and/or a GLP-1 receptor agonist (e.g., Byetta, Bydureon, Trulicity, Victoza)?	<input type="checkbox"/> Yes <i>Submit documentation of treatment regimen tried and HbA1c results.</i> <input type="checkbox"/> No		

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

Prescriber Signature:	Date:
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