

HYPOGLYCEMICS, TZDs PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hypoglycemics, TZDs** 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 pgs: _____	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:	Strength:
Dose/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, contraindication, or intolerance of maximum tolerated doses of metformin ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation showing trial and failure of, or contraindication or intolerance to, metformin (including result of a recent HbA1c).</i>
<u>Requests for NON-PREFERRED agents:</u> Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Hypoglycemics, TZDs? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class.	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</i>

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

Prescriber Signature:	Date:
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