

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

PRIOR AUTHORIZATION FORM (form effective 1/8/2024)

Prior authorization guidelines for **Hypoglycemics, Incretin Mimetics/Enhancers** 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:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:	Quantity:	Refills:	
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

Complete all sections that apply to the beneficiary and this request.

*Check all that apply and **submit documentation** for each item.*

INITIAL requests

1. For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:

Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred GLP-1 receptor agonists.*)

Attestation from the prescriber:

The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

The beneficiary is 18 years of age or older:

Pre-treatment weight: _____ Pre-treatment BMI: _____

Has a BMI greater than or equal to 30 kg/m²

Has a BMI greater than or equal 27 kg/m² and less than 30 kg/m² and at least one of the following weight-related comorbidities:

dyslipidemia

obstructive sleep apnea

hypertension

prediabetes

metabolic syndrome

type 2 diabetes

other (list): _____

Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for

beneficiary's ethnicity, etc. and has at least one of the following weight-related comorbidities:

- | | |
|--|--|
| <input type="checkbox"/> dyslipidemia | <input type="checkbox"/> obstructive sleep apnea |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> prediabetes |
| <input type="checkbox"/> metabolic syndrome | <input type="checkbox"/> type 2 diabetes |
| <input type="checkbox"/> other (list): _____ | |

The beneficiary is less than 18 years of age:

Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

2. For the treatment of ALL OTHER diagnoses:

Request is for a non-preferred GLP-1 receptor agonist:

Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists.)

Request is for a non-preferred DPP-4 inhibitor:

Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.)

Request is for non-preferred Symlin (pramlintide)

RENEWAL requests

For a non-preferred **GLP-1 RECEPTOR AGONIST** for the treatment of **OBESITY**:

Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred GLP-1 receptor agonists.)

The dose of the requested medication is currently being titrated

The beneficiary is experiencing clinical benefit with the requested medication

Attestation from the prescriber:

The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

The beneficiary is 18 years of age or older:

Pre-treatment weight: _____ Current weight: _____

The beneficiary is less than 18 years of age:

Pre-treatment BMI: _____ Current BMI: _____

Pre-treatment BMI z-score: _____ Current BMI z-score: _____

The beneficiary is being treated for a diagnosis **OTHER THAN OBESITY**.

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

Prescriber Signature:	Date:
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