

**Request for Prior Authorization**  
**ANTI-DIABETIC NON-INSULIN AGENTS**  
 (PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #		Patient name	DOB
Patient address			
Provider NPI		Prescriber name	Phone
Prescriber address			Fax
Pharmacy name		Address	Phone
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
Pharmacy NPI		Pharmacy fax	NDC

**Prior authorization (PA) is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1) Patient has an FDA approved or compendia indicated diagnosis; and 2) Patient meets the FDA approved or compendia indicated age; and 3) For the treatment of Type 2 Diabetes Mellitus, the patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose. 4) Requests for non-preferred anti-diabetic, non-insulin agents subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor at maximally tolerated doses.**

**The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.**

**Initial authorizations will be approved for six months. Additional PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).**

**Preferred DPP-4 Inhibitors and Combinations (PA Required)**

- |                                     |                                    |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Janumet    | <input type="checkbox"/> Jentaduo  |
| <input type="checkbox"/> Janumet XR | <input type="checkbox"/> Tradjenta |
| <input type="checkbox"/> Januvia    |                                    |

**Non- Preferred DPP-4 Inhibitors and Combinations**

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Alogliptin              | <input type="checkbox"/> Jentaduo XR   | <input type="checkbox"/> Onglyza     |
| <input type="checkbox"/> Alogliptin-Metformin    | <input type="checkbox"/> Kazano        | <input type="checkbox"/> Oseni       |
| <input type="checkbox"/> Alogliptin-Pioglitazone | <input type="checkbox"/> Kombiglyze XR | <input type="checkbox"/> Trijardy XR |
| <input type="checkbox"/> Glyxambi                | <input type="checkbox"/> Nesina        |                                      |

**Preferred Incretin Mimetics (PA required)**

- |                                   |                                    |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Byetta   | <input type="checkbox"/> Trulicity |
| <input type="checkbox"/> Bydureon | <input type="checkbox"/> Victoza   |

**Non-Preferred Incretin Mimetics**

- |   |                                   |
|---|-----------------------------------|
| <input type="checkbox"/> Adlyxin        | <input type="checkbox"/> Ozempic  |
| <input type="checkbox"/> Bydureon BCise | <input type="checkbox"/> Rybelsus |

**Preferred SGLT2 Inhibitors and Combinations (No PA Required)**

- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Farxiga   | <input type="checkbox"/> Jardiance |
| <input type="checkbox"/> Invokamet | <input type="checkbox"/> Synjardy  |
| <input type="checkbox"/> Invokana  | <input type="checkbox"/> Xigduo XR |

**Non-Preferred SGLT2 Inhibitors and Combinations**

- |                                       |                                     |                                      |
|---------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Invokamet XR | <input type="checkbox"/> Segluromet | <input type="checkbox"/> Steglujan   |
| <input type="checkbox"/> Qtern        | <input type="checkbox"/> Steglatro  | <input type="checkbox"/> Synjardy XR |

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____



**FAX Completed Form To**  
 1.833.404.2392  
**Pharmacy Help Desk**  
 1.800.460.8988  
**Prescriber Help Desk**  
 1.833.587.2012

**Request for Prior Authorization**  
**ANTI-DIABETICS NON-INSULIN AGENTS**  
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**Diagnosis:** \_\_\_\_\_

**Type 2 Diabetes Mellitus**

Metformin Trial: Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_ Trial dose: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

**Most recent HgbA1C Level:** \_\_\_\_\_ **Date this level was obtained:** \_\_\_\_\_

**Requests for Non-Preferred Drugs:**

**Preferred DPP-4 Trial:** Drug Name/Dose: \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Preferred Incretin Mimetic Trial:** Drug Name/Dose: \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Preferred SGLT2 Trial:** Drug Name/Dose: \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

Reason for use of Non-Preferred drug requiring prior approval: \_\_\_\_\_

**Other diagnosis:** \_\_\_\_\_

**Trial of preferred drug in the same class:** Drug Name/Dose: \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Renewals**

**Document continued improvement in symptoms:** \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.