

**Request for Prior Authorization
ANTI-DIABETICS NON-INSULIN AGENTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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.