

## HYPOGLYCEMICS, INSULIN PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Insulin Hypoglycemic agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Hypoglycemics, Insulin** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:	
<input type="checkbox"/> Renewal request	(PA#: _____)	_____		
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:	

### CLINICAL INFORMATION

<b>Non-preferred medication requested*:</b> (*NOTE: For Afrezza requests, please call the Pharmacy Services help desk.)			
<b>Rapid-acting</b> <input type="checkbox"/> Apidra vial <input type="checkbox"/> Apidra Solostar pen <input type="checkbox"/> Humalog U-100 cartridge/Kwikpen <input type="checkbox"/> Humalog U-200 Kwikpen	<b>Intermediate-acting</b> <input type="checkbox"/> Humulin N Kwikpen	<b>Long-acting (basal)</b> <input type="checkbox"/> Toujeo U-300 Solostar pen <input type="checkbox"/> Tresiba U-100 FlexTouch pen <input type="checkbox"/> Tresiba U-200 FlexTouch pen	<b>Insulin mixes</b> <input type="checkbox"/> Humalog Mix 50/50 Kwikpen <input type="checkbox"/> Humalog Mix 75/25 Kwikpen <input type="checkbox"/> Humulin 70/30 Kwikpen
Directions:	Quantity:	Refills:	
Diagnosis ( <u>submit documentation</u> ):		Dx code ( <u>required</u> ):	
1. Has the Recipient tried and failed any of the preferred Insulin Hypoglycemic agents? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure</u> <input type="checkbox"/> No	
<b>Rapid-acting</b> <input type="checkbox"/> Humalog vial <input type="checkbox"/> NovoLog vial, cartridge, or Flexpen	<b>Short-acting</b> <input type="checkbox"/> Humulin R U-100 vial <input type="checkbox"/> Humulin R U-500 vial <input type="checkbox"/> Novolin R U-100 vial		
<b>Long-acting (basal)</b> <input type="checkbox"/> Lantus vial or Solostar pen <input type="checkbox"/> Levemir vial or FlexTouch pen	<b>Insulin mixes</b> <input type="checkbox"/> Humalog Mix 75-25 vial <input type="checkbox"/> Humalog Mix 50-50 vial <input type="checkbox"/> Humulin 70/30 vial	<input type="checkbox"/> Novolin 70/30 vial <input type="checkbox"/> NovoLog Mix 70/30 vial or Flexpen	
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of medication name(s) and associated intolerances and contraindications</u> <input type="checkbox"/> No	
3. Does the Recipient have a diagnosis of diabetes mellitus (type 1 or type 2)?		<input type="checkbox"/> Yes – <u>submit documentation of diagnosis</u> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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