



Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates: 1) The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin (not applicable for pediatric patients), and 2) There is no caregiver available to provide assistance, and 3) Patient does not reside in a long-term care facility.

Preferred

- Lantus SoloSTAR
Levemir FlexTouch
Novolog Flexpen
Novolog PenFill
NovoLog Mix 70/30 Cartridge
NovoLog Mix 70/30

Non-Preferred

- Apidra SoloSTAR
Humalog KWP
Humalog Mix 75/25 Pen
Humalog Mix 50/50 Pen
Humulin N Pen
Humulin R Pen
Humulin 70/30 Pen
Toujeo SoloStar
Tresiba FlexTouch

Number of Units

How Often

Number of Cartridges/Pens/PenFills (circle requested item)

Diagnosis:

What visual or physical conditions limit the patient's ability to prepare their own syringes (adult patients only)?

Does the patient lack capable assistance residing with them? Yes No

Does the patient reside in a long-term care facility? Yes No

Other medical conditions to consider:

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

Attach lab results and other documentation as necessary.

Table with 2 columns: Prescriber signature (Must match prescriber listed above.) and Date of submission

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.