



Request for Prior Authorization
ANTI-DIABETIC NON-INSULIN AGENTS

(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 preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1) A diagnosis of Type 2 Diabetes Mellitus, and 2) Patient is 18 years of age or older; and 3) The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated.

Preferred DPP-4 Inhibitors and Combinations

- Janumet, Janumet XR, Januvia, Jentadueto, Tradjenta

Non- Preferred DPP-4 Inhibitors and Combinations

- Alogliptin, Alogliptin-Metformin, Alogliptin-Pioglitazone, Glyxambi, Kazano, Kombiglyze XR, Nesina, Onglyza, Oseni

Preferred Incretin Mimetics

- Byetta, Tanzeum

Non-Preferred Incretin Mimetics

- Bydureon, Trulicity, Victoza

Non-Preferred SGLT2 Inhibitors and Combinations

- Farxiga, Invokamet, Invokana, Jardiance, Synjardy, Xigduo XR

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Metformin Trial: Trial start date: Trial end date: Trial dose:

Reason for Failure:

Medical or contraindication reason to override trial requirements:

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Most recent HgbA1C Level: _____ Date this level was obtained: _____

Requests for Non-Preferred Drugs:

DPP-4 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Incretin Mimetic Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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

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.*