Request for Prior Authorization: Antidiabetic Noninsulin Agents

Iowa | Iowa Health Link • Hawki

Contains confidential patient information

Instructions

Complete this form in its entirety and fax it to the Prior Authorization of Benefits Center at **844-512-9004**. If you have any questions, use the Chat with Payer feature in https://Availity.com or contact Provider Services at **833-731-2143**, Monday through Friday, 7:30 a.m. to 6 p.m. CT.

1. Patient information

2. Provider and pharmacy information

IA Medicaid member ID:	Prescriber NPI:
Patient name:	Prescriber name:
DOB:	Prescriber phone:
Patient address:	Prescriber address:
	Prescriber fax:
	Pharmacy name:
	Pharmacy address:
	Pharmacy phone:
Prescriber must complete all information above. It must be legible, correct, and complete, or the form will be returned.	
Pharmacy NPI:	Pharmacy fax:
NDC:	

3. Approval criteria

Prior authorization (PA) is required for select preferred antidiabetic, noninsulin agents subject to Clinical Criteria. Payment will be considered under the following conditions:

1. Request adheres to all FDA-approved labeling for the requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and
3. Requests for combination therapy with a DPP-4 inhibitor containing agent with a GLP-1 receptor agonist containing agent will not be considered; and
4. Requests for nonpreferred antidiabetic, noninsulin 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. Additionally, requests for a nonpreferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with at least three preferred agents from three different drug classes at maximally tolerated doses.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Requests for weight loss, which is not a covered diagnosis of use and will be denied.

4. Drug selection

Preferred DPP-4 inhibitors and combinations (no PA required)

- ☐ Janumet
- ☐ Januvia
- ☐ Jentadueto
- ☐ Jentadueto XR
- ☐ Tradjenta

Nonpreferred DPP-4 inhibitors and combinations

- ☐ Alogliptin
- ☐ Alogliptin-Metformin
- ☐ Alogliptin-Pioglitazone
- ☐ Brynovin
- ☐ Glyxambi
- ☐ Janumet XR
- ☐ Kazano
- ☐ Kombiglyze XR
- ☐ Nesina
- ☐ Onglyza
- ☐ Oseni
- ☐ Saxagliptin
- ☐ Saxagliptin-Metformin ER
- ☐ Sitagliptin
- ☐ Sitagliptin-Metformin
- ☐ Trijardy XR
- ☐ Zituvimet
- ☐ Zituvimet XR
- ☐ Zituvio

Preferred GLP-1 RAs (PA required)

- ☐ Exenatide
- ☐ Mounjaro
- ☐ Ozempic
- ☐ Rybelsus
- ☐ Trulicity
- ☐ Victoza

Nonpreferred GLP-1 RAs and combinations

- ☐ Bydureon BCise
- ☐ Byetta
- ☐ Liraglutide

Preferred SGLT2 inhibitors and combinations (no PA required)

☐ Farxiga
☐ Jardiance
☐ Synjardy
☐ Xigduo XR

Nonpreferred SGLT2 inhibitors and combinations

☐ Dapagliflozin
☐ Dapagliflozin/Metformin
☐ Invokamet
☐ Invokamet XR
☐ Invokana
☐ Qtern
☐ Segluromet
☐ Steglatro
☐ Steglujan
☐ Synjardy XR

Strength	Dosage instructions	Quantity	Days supply

5. Diagnosis

☐ **Type 2 Diabetes Mellitus**

Most recent A1C level: _____ Date this level was obtained: _____

Requests for DPP-4 inhibitor or GLP-1 receptor agonist-containing agents

Is combination DPP-4 inhibitor or GLP-1 receptor agonist-containing agents being used?

☐ Yes ☐ No

Requests for nonpreferred drugs

Preferred drug trial 1			
Name and dose		Trial dates	
Failure reason			

Preferred drug trial 2			
Name and dose		Trial dates	
Failure reason			

Preferred drug trial 3			
Name and dose		Trial dates	
Failure reason			

Medical or contraindication reason to override trial requirements:

☐ **Other diagnosis**

Provide other diagnosis:

Trial of preferred drug in the same class			
Name and dose		Trial dates	
Failure reason			

Attach lab results and other documentation as necessary.

6. Physician signature

Prescriber or authorized signature
Must match prescriber named above.

Date submitted

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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 care 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 Health and Human Services, that the member continues to be eligible for Medicaid.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled in your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium, including mail, email, fax, or other electronic transmission.