Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hypoglycemics - Insulins and Related Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for an insulin and glucagon-like peptide-1 (GLP-1) receptor agonist combination (e.g., Soliqua, Xultophy)?
[If no, then skip to question 10.]

☐ Yes ☐ No

Q2. Will the patient be using the requested drug in combination with any other product containing a glucagon-like peptide-1 (GLP-1) receptor agonist?

☐ Yes ☐ No

Q3. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q4. Does the patient have improved glycemic control, as evidenced by a recent hemoglobin A1c (HbA1c) value?

☐ Yes ☐ No

Q5. Does the patient have the diagnosis of type 2 diabetes mellitus?

☐ Yes ☐ No

Q6. Does the patient have a documented history of a failure to achieve glycemic control using maximum tolerated doses of metformin, as evidenced by the patient's hemoglobin A1c (HbA1c) values?

☐ Yes ☐ No

Q7. Does the patient have a documented history of a contraindication to or intolerance of metformin?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Has the patient failed to achieve glycemic control using basal insulin, as evidenced by the patient's hemoglobin A1c (HbA1c) values?	
☐ Yes	☐ No
Q9. Has the patient failed to achieve glycemic control using a preferred glucagon-like peptide-1 (GLP-1) receptor agonist (e.g., Victoza, Trulicity), as evidenced by the patient's hemoglobin A1c (HbA1c) values?	
☐ Yes	☐ No
Q10. Is this a request for Afrezza? [If no, then skip to question 31.]	
☐ Yes	☐ No
Q11. Is the requested drug being prescribed by or in consultation with an endocrinologist?	
☐ Yes	☐ No
Q12. Does the patient have any contraindications to Afrezza?	
☐ Yes	☐ No
Q13. Does the patient have a documented medical history of abstinence from smoking for at least 6 months and is NOT currently a smoker?	
☐ Yes	☐ No
Q14. Is this a request for a renewal of authorization? [If no, then skip to question 20.]	
☐ Yes	☐ No
Q15. Does the patient have improved glycemic control, as evidenced by a recent documented hemoglobin A1c (HbA1c) value?	
☐ Yes	☐ No
Q16. Has the patient been evaluated for lung function using spirometry testing approximately 6 months after starting Afrezza AND will continue to be evaluated annually thereafter?	
☐ Yes	☐ No
Q17. Did the patient have a decline in forced expiratory volume (FEV1) greater than 20 percent from baseline since starting Afrezza?	
☐ Yes	☐ No

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Q18. Did the patient experience any bronchospasm, wheezing, or other respiratory difficulties after using Afrezza?

☐ Yes ☐ No

Q19. Does the patient have active lung cancer?

☐ Yes ☐ No

Q20. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q21. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of short- and rapid-acting injectable insulin and related agents?

☐ Yes ☐ No

Q22. Has the patient been evaluated for lung function, including a documented detailed medical history, physical examination, and spirometry testing?

☐ Yes ☐ No

Q23. Does the patient have active lung cancer OR a history of lung cancer?

☐ Yes ☐ No

Q24. Will the patient be assessed for lung function using spirometry testing six (6) months after initiating Afrezza AND annually thereafter?

☐ Yes ☐ No

Q25. Does the patient have a documented baseline hemoglobin A1c (HbA1c)?

☐ Yes ☐ No

Q26. Does the patient have a diagnosis of type 1 diabetes mellitus?

☐ Yes ☐ No

Q27. Will the patient be using Afrezza in conjunction with a long-acting insulin?
[If yes, then skip to question 32.]

☐ Yes ☐ No

Q28. Does the patient have a diagnosis of type 2 diabetes mellitus?

☐ Yes ☐ No

Q29. Does the patient have a documented history of a failure to achieve glycemic control using maximum tolerated doses of metformin in combination with maximum tolerated doses of the second line agents used to treat type 2 diabetes in accordance with the most recent American Diabetes Association (ADA) guidelines, as evidenced by the

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Patient Name:	Prescriber Name:

patient's hemoglobin A1c (HbA1c) values?

☐ Yes ☐ No

Q30. Does the patient have a documented history of a contraindication to or intolerance of metformin and the second line agents used to treat type 2 diabetes, in accordance with the most recent American Diabetes Association (ADA) guidelines?

☐ Yes ☐ No

Q31. Does the patient have a diagnosis of type 1 or type 2 diabetes mellitus?

☐ Yes ☐ No

Q32. Does the patient have a documented history of a contraindication to or intolerance of the preferred insulin drugs (e.g., Apidra, Humalog Mix 50-50, Humalog Mix 75-25, Humulin 70/30, Humulin R 500 units/mL, insulin lispro, Lantus, Levemir, Novolog, Novolog Mix 70-30) that would not be expected to occur with the requested drug?

☐ Yes ☐ No

Q33. Additional Information:

Prescriber Signature

Date

Updated for 2022

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