

Renewal request

■New request

**FAX FORM AND CLINICAL DOCUMENTATION** 

## HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

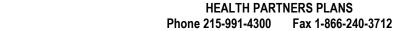
PRIOR AUTHORIZATION FORM (form effective 1/8/2024)

Prior authorization guidelines for Hypoglycemics, Incretin Mimetics/Enhancers and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at <a href="https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx">https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx</a>.

total # of pgs: \_

Prescriber name:

Name of office contact:		Specialty:			
Contact's phone number:		NPI:	State licens	State license #:	
LTC facility contact/phone:		Street address:			
Beneficiary name:		City/state/zip:			
Beneficiary ID#:	DOB:	Phone: Fax:			
CLINICAL INFORMATION					
Drug requested:			Strength:		
Dose/directions:		Quantity:	Refills:		
Diagnosis (submit documentation):			Dx code ( <u>required</u> ):		
Complete all sections that apply to the beneficiary and this request.  Check all that apply and submit documentation for each item.					
INITIAL requests					
1. For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:					
Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred GLP-1 receptor agonists.)					
☐ Attestation from the prescriber: ☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity					
☐The beneficiary is 18 years of age or older:					
Pre-treatment weight: Pre-treatment BMI:					
☐Has a BMI greater than or equal to 30 kg/m²					
☐ Has a BMI greater than or equal 27 kg/m² and less than 30 kg/m² and at least one of the following weight-related comorbidities:					
☐dyslipidemia ☐obstructive sleep apnea					
hypertension		prediabetes			
metabolic syndrome					
other (list):					
☐ Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for  Page 1 of 2					





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beneficiary's ethnicity, etc. and has at least one of the following weight-related comorbidities:				
□dyslipidemia	obstructive sleep apnea			
hypertension	prediabetes			
metabolic syndrome	☐type 2 diabetes			
other (list):	<del></del>			
☐The beneficiary is <u>less than 18 years of age</u> :				
Pre-treatment BMI: Pre-treatment BMI z-score:				
☐ Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts				
2. For the treatment of ALL OTHER diagnoses:				
Request is for a non-preferred GLP-1 receptor agonist:  Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists.)				
Request is for a non-preferred DPP-4 inhibitor:  Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.)				
Request is for non-preferred Symlin (pramlintide)				
RENEWAL requests				
☐ For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:				
Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred GLP-1 receptor agonists.)				
The dose of the requested medication is currently being titrated				
The beneficiary is experiencing clinical benefit with the requested medication				
☐ Attestation from the prescriber: ☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity				
☐The beneficiary is 18 years of age or older:				
Pre-treatment weight:	Current weight:			
☐The beneficiary is <u>less than 18 years of age</u> :				
Pre-treatment BMI:	Current BMI:			
Pre-treatment BMI z-score:	Current BMI z-score:			
☐ The beneficiary is being treated for a diagnosis OTHER THAN OBESITY.				
PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712				
Prescriber Signature:	Date:			

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