

Hypoglycemic, Incretin Mimetics-Enhancers - Pennsylvania Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:		Specialty:
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:		Allergies:	City:	State:	ZIP Code:
Medication Information					
Medication:				Strength:	
Directions for use:				Quantity:	
Medication Administered: <input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other: _____					
Clinical Information					
What is the patient's diagnosis for the medication being requested? _____ _____					
ICD-10 Code(s): _____					
Are there any supporting laboratory or test results related to the patient's diagnosis? <i>(Please specify or provide documentation)</i>					
Previous Medication Trials / Contraindications					
<u>Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives</u>					
What medication(s) does the patient have a history of failure to? <i>(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)</i>					
What medication(s) does the patient have a contraindication or intolerance to? <i>(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)</i>					
Additional information that may be important for this review					

Member First name:	Member Last name:	Member DOB:
Clinical and Drug Specific Information		
ALL REQUESTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of type 2 diabetes mellitus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed to treat obesity?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented history of any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Failure to achieve glycemic control as evidenced by the patient's HbA1c (hemoglobin A1c) values using maximum tolerated doses of metformin <input type="checkbox"/> A contraindication or intolerance to metformin <input type="checkbox"/> The patient requires initial dual therapy with metformin based on HbA1c as defined by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology <input type="checkbox"/> If the requested medication has proven cardiovascular disease (CVD), heart failure (HF), or chronic kidney disease (CKD) benefit, the patient has CVD (or two risk factors for CVD as identified by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology), HF, or CKD	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented history of therapeutic failure, contraindication, or intolerance of the preferred incretin mimetics/enhancers with the same mechanism of action? <i>(If yes, complete "Previous Medication Trials/Contraindications" section on first page)</i>	
SYMLIN PEN		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of type 1 diabetes mellitus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient failed to achieve adequate glycemic control as evidenced by the patient's HbA1c values despite compliance with optimal insulin therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be prescribed in combination with insulin?	
CONTINUATION OF THERAPY – SYMLIN PEN		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have improved glycemic control as evidenced by a recent HbA1c (hemoglobin A1c) value?	
THERAPEUTIC DUPLICATION		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient being transitioned to or from another incretin mimetic/enhancer with the intent of discontinuing one of the medications?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the prescriber have a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?	

Provider Signature: _____ **Date:** _____

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