

Request for Prior Authorization
ANTI-DIABETIC
NON-INSULIN AGENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Strength

Dosage Instructions

Quantity

Days Supply

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 and GLP-1 receptor agonist containing agents being used?

Yes No

Requests for Non-Preferred Drugs:

Preferred Trial 1: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred Trial 2: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred Trial 3: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Medical or contraindication reason to override trial requirements: _____

Other diagnosis: _____

Trial of preferred drug in the same class: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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