



Request for Prior Authorization
ANTI-DIABETIC
NON-INSULIN AGENTS

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464



(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, and Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for select preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:

- 1. Request adheres to all FDA approved labeling for 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 non-preferred antidiabetic, non-insulin 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.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Requests for weight loss are not a covered diagnosis of use and will be denied.

Preferred DPP-4 Inhibitors and Combinations (No PA Required)

- Janumet
Janumet XR
Januvia
Jentadueto
Trijardy

Non- Preferred DPP-4 Inhibitors and Combinations

- Alogliptin, Nesina, Zituvio, Alogliptin-Metformin, Onglyza, Alogliptin-Pioglitazone, Oseni, Glyxambi, Saxagliptin, Jentadueto XR, Saxagliptin-Metformin ER, Kazano, Sitagliptin, Kombiglyze XR, Trijardy XR

Preferred GLP-1 RAs (PA required)

- Bydureon, Trulicity, Ozempic, Victoza

Non-Preferred GLP-1 RAs and Combinations

- Adlyxin, Byetta, Rybelsus, Bydureon BCise, Mounjaro

Preferred SGLT2 Inhibitors and Combinations (No PA Required)

- Farxiga, Jardiance, Invokamet, Synjardy, Invokana, Xigduo XR

Non-Preferred SGLT2 Inhibitors and Combinations

- Dapagliflozin, Qtern, Steglujan, Dapagliflozin/Metformin, Segluromet, Synjardy XR, Invokamet XR, Steglatro

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: _____

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Type 2 Diabetes Mellitus

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

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.