MOLINA HEALTHCARE

Iowa Health Link IOWA HHS Hawki Iowa HHS

Request for Prior Authorization

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

ANTI-DIABETIC NON-INSULIN AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for 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, the patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose. 3) Requests for non-preferred anti-diabetic, 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. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination, a preferred GLP-1 RA, and a preferred SGLT2 Inhibitor at maximally tolerated doses.
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.
Initial authorizations will be approved for six months. Additional PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).

Preferred DPP-4 Inhibitors and Combinations (PA Required)

- ☐ Janumet
- ☐ Janumet XR
- ☐ Januvia
- ☐ Jentadueto
- ☐ Tradjenta

Non- Preferred DPP-4 Inhibitors and Combinations

- ☐ Alogliptin
- ☐ Alogliptin-Metformin
- ☐ Alogliptin-Pioglitazone
- ☐ Glyxambi
- ☐ Jentadueto XR
- ☐ Kazano
- ☐ Kombiglyze XR
- ☐ Nesina
- ☐ Onglyza
- ☐ Oseni
- ☐ Trijardy XR

Preferred GLP-1 RAs (PA required)

- ☐ Bydureon
- ☐ Ozempic
- ☐ Trulicity
- ☐ Victoza

Non-Preferred GLP-1 RAs and Combinations

- ☐ Adlyxin
- ☐ Bydureon BCise
- ☐ Byetta
- ☐ Mounjaro
- ☐ Rybelsus

Preferred SGLT2 Inhibitors and Combinations (No PA Required)

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

Non-Preferred SGLT2 Inhibitors and Combinations

- ☐ Invokamet XR
- ☐ Qtern
- ☐ Segluromet
- ☐ Steglatro
- ☐ Steglujan
- ☐ Synjardy XR

Strength	Dosage Instructions	Quantity	Days Supply

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ANTI-DIABETICS NON-INSULIN AGENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis: _____

☐ **Type 2 Diabetes Mellitus**

Metformin Trial: Trial start date: _____ Trial end date: _____ Trial dose: _____

Reason for Failure: _____

Medical or contraindication reason to override trial requirements: _____

_____

Most recent HgbA1C Level: _____ Date this level was obtained: _____

Requests for Non-Preferred Drugs:

Preferred DPP-4 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred GLP-1 RA Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred SGLT2 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

_____

☐ **Other diagnosis:** _____

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

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

☐ **Renewals**

Document continued improvement in symptoms: _____

_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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