Iowa Department of Human Services

Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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 is required for all pre-filled insulin pens. For pre-filled insulin pens where the requested insulin is available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin (not applicable for pediatric patients), and 2) There is no caregiver available to provide assistance, and 3) Patient does not reside in a long-term care facility, and 4) For requests for non-preferred pre-filled pens, patient has documentation of a previous trial and therapy failure with a preferred pre-filled insulin pen within the same class (i.e. rapid, regular or basal). For pre-filled insulin pens where the requested insulin is not available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) Preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular, or basal) or clinical rationale as to why the patient cannot use a preferred insulin agent, and 2) Non-preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular or basal). 3) Requests for Toujeo will require clinical rationale as to why the patient cannot use Lantus and patient must be using a minimum of 100 units of Lantus per day.

Preferred (available in vial)
- ☐ Lantus SoloSTAR
- ☐ Levemir FlexTouch
- ☐ Novolog Flexpen
- ☐ Novolog PenFill
- ☐ NovoLog Mix 70/30 Cartridge
- ☐ NovoLog Mix 70/30

Non-Preferred (available in vial)
- ☐ Apidra SoloSTAR
- ☐ Humalog KWP
- ☐ Humalog Mix 75/25 Pen
- ☐ Humalog Mix 50/50 Pen
- ☐ Humulin N KwikPen
- ☐ Humulin R KwikPen
- ☐ Humulin 70/30 KwikPen

Non-Preferred (not available in vial)
- ☐ Basaglar KwikPen
- ☐ Toujeo SoloStar
- ☐ Tresiba FlexTouch

Number of Units _____ **How Often** _____ **Number of Cartridges/Pens/PenFills (circle requested item)** _____

Diagnosis: _____

☐ **Requests for insulin agents available in a vial:**

What visual or physical conditions limit the patient's ability to prepare their own syringes (adult patients only)?

_____

Does the patient lack capable assistance residing with them? ☐ Yes ☐ No

Does the patient reside in a long-term care facility? ☐ Yes ☐ No

Requests for a non-preferred pre-filled insulin pen, document preferred pre-filled insulin pen trial within the same class:

Drug Name and Dosage Instructions:_____ Trial start date: _____Trial end date:____
Failure Reasons: _____
_____

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☐ **Requests for insulin agents not available in a vial:**

Document Preferred Insulin Trial in same class as requested agent:

Drug Name and Dosage Instructions:_____ Trial start date: _____Trial end date:____
Failure Reasons: _____
_____

Toujeo:

Patient's current daily Lantus dose: _____

Clinical rationale as to why patient cannot use Lantus: _____
_____

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.*