



Request for Prior Authorization
GLP-1 Agonist/Basal Insulin Combinations

(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, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met:

- 1) A diagnosis of Type 2 Diabetes Mellitus, and
2) Patient is 18 years of age or older; and
3) The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated; and
4) Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and
5) Will not be used concurrently with prandial insulin; and
6) Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and
7) Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of:
a) Soliqua below 15 units or over 60 units, or
b) Xultophy persistently below 16 units or over 50 units.

Non-Preferred

[] Soliqua [] Xultophy

Strength

Dosage Instructions

Quantity

Day's Supply

Diagnosis: _____

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

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

Reason for failure: _____

Medical or contraindication reason to override trial requirements: _____

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Preferred GLP-1 Receptor Agonist Trial: Drug name/dose: _____

Trial start date: _____ Trial end date: _____

Reason for failure: _____

Preferred Long-Acting Insulin Trial: Drug name/dose: _____

Trial start date: _____ Trial end date: _____

Reason for failure: _____

Clinical rationale as to why patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently: _____

Is prandial insulin being used concurrently? Yes No

Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of:

Soliqua – below 15 units or over 60 units Yes No

Xultophy – persistently below 16 units or over 50 units Yes No

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