Iowa Department of Human Services

Request for Prior Authorization
ANTI-DIABETIC NON-INSULIN AGENTS

(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 preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 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. Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination and a preferred Incretin Mimetic at maximally tolerated doses, unless evidence is provided that use of these agents would be medically contraindicated. Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

Preferred DPP-4 Inhibitors and Combinations

- ☐ 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

Preferred Incretin Mimetics

- ☐ Byetta

Non-Preferred Incretin Mimetics

- ☐ Adlyxin
- ☐ Bydureon
- ☐ Trulicity
- ☐ Victoza

Non-Preferred SGLT2 Inhibitors and Combinations

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

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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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:

DPP-4 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Incretin Mimetic Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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

_____

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.*