



Request for Prior Authorization
ANTI-DIABETIC NON-INSULIN AGENTS

(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, 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.

Preferred DPP-4 Inhibitors and Combinations

- Janumet, Janumet XR, Januvia, Jentaduetto, Tradjenta

Non- Preferred DPP-4 Inhibitors and Combinations

- Alogliptin, Alogliptin-Metformin, Alogliptin-Pioglitazone, Glyxambi, Jentaduetto XR, Kazano, Kombiglyze XR

Preferred Incretin Mimetics

- Byetta, Bydureon

Non-Preferred Incretin Mimetics

- Adlyxin, Trulicity, Victoza

Preferred SGLT2 Inhibitors and Combinations

- Farxiga, Jardiance, Synjardy, Synjardy XR, Xigduo XR

Non-Preferred SGLT2 Inhibitors and Combinations

- Invokamet, Invokamet XR, Invokana

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: \_\_\_\_\_

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**ANTI-DIABETICS NON-INSULIN AGENTS**  
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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
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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.*