



Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(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, and NDC.

Prior authorization (PA) is required for pre-filled insulin pens as designated on the Preferred Drug List (PDL). For pre-filled insulin pens requiring PA 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).

Preferred (no PA required)

- Options for preferred insulin pens: Lantus SoloSTAR, Levemir FlexTouch, NovoLog FlexPen/PenFill, Novolog Mix FlexPen.

PA Required:

Non-Preferred (available in vial)

- Options for non-preferred insulin pens 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)

- Options for non-preferred insulin pens 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



**Request for Prior Authorization  
INSULIN, PRE-FILLED PENS**

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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: \_\_\_\_\_

**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
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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.*