

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GLUCAGON-LIKE
PEPTIDE (GLP-1) AGENTS**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents Completion Instructions, F-00238A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR ALL REQUESTS

13. Diagnosis Code and Description

14. Is the member 18 years of age or older? Yes No

15. Is the member currently receiving Lantus insulin injections? Yes No

16. Is the member currently receiving insulin injections other than Lantus insulin? Yes No

17. Does the member currently have or is there a history of pancreatitis? Yes No

18. Does the member currently have or is there a history of gastroparesis? Yes No

19. Is the member participating in lifestyle interventions (e.g., diet, exercise) to improve glucose control? Yes No

Continued



DT-PA091-091

SECTION III — CLINICAL INFORMATION FOR ALL REQUESTS (Continued)

20. Indicate the member's most current hemoglobin (HbA1c).

_____. _____. _____ %

21. Date Member's HbA1c Measured (Within the Past Six Months)

_____/_____/_____
Month Date Year

22. Has the member been taking the maximum effective dose of metformin (1,700 mg/day to 2,500 mg/day) for the past three months? Yes No

23. Is the member currently taking and will continue to take the maximum effective dose of metformin? Yes No

24. Is the member unable to take the maximum effective dose of metformin? Yes No

If yes, indicate the reason(s) why the member is not taking the maximum effective dose of metformin in the space provided.

25. Has the member been taking the maximum effective dose of a sulfonylurea for the past three months? Yes No

26. Is the member currently taking and will continue to take the maximum effective dose of a sulfonylurea? Yes No

If yes, indicate the drug name, dose, and directions for use in the space provided.

27. Is the member unable to take the maximum effective dose of a sulfonylurea? Yes No

If yes, indicate the reason(s) why the member is not taking the maximum effective dose of a sulfonylurea in the space provided.

28. Is the member currently using a GLP-1 agent? Yes No

If yes, complete Section IIIA of this form.

SECTION IIIA — CLINICAL INFORMATION FOR MEMBERS CURRENTLY USING A GLP-1 AGENT

29. Has the member been using a GLP-1 agent for the past six months? Yes No

30. Since starting a GLP-1 agent, has the member's most current HbA1c decreased by at least 0.5 percent? Yes No

31. Since starting a GLP-1 agent, has the member's HbA1c dropped below seven percent? Yes No

SECTION IIIB — CLINICAL INFORMATION FOR VICTOZA REQUESTS ONLY (Complete this section only for PA requests for Victoza. Prior authorization requests for Victoza must be submitted on paper.)

32. Has the member tried and failed on the maximum dose of Byetta? Yes No

If yes, indicate the dose, directions for use, and the approximate dates Byetta was used in the space provided. In addition, describe in detail how the member failed to achieve an adequate therapeutic response or why the member is unable to continue treatment with Byetta.

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

33. National Drug Code (11 Digits)

34. Days' Supply Requested (Up to 365 Days)

35. NPI

36. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

37. Place of Service

38. Assigned PA Number

39. Grant Date

40. Expiration Date

41. Number of Days Approved

SECTION V — AUTHORIZED SIGNATURE

42. **SIGNATURE** — Prescriber

43. Date Signed

SECTION VI — ADDITIONAL INFORMATION

44. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.
