

**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](http://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, by fax, or by mail. 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 (Required for all PA requests.)**

13. Diagnosis Code and Description

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

15. Is the member currently receiving long-acting insulin injections (e.g., Lantus, Levemir®)?  Yes  No

16. Is the member currently receiving rapid-acting or short-acting insulin injections?  Yes  No

17. Is the member currently receiving intermediate-acting or premixed insulin injections?  Yes  No

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

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

20. 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 (Required for all PA requests.) (Continued)**

21. Indicate the member's most current hemoglobin (HbA1c).  _____ . _____ %	22. Date Member's HbA1c Measured (Within the Past Six Months)  _____ / _____ / _____ Month                      Date                      Year
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23. 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

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

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

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

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

If yes, also complete Section IIIA of this form.

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

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

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

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

**SECTION IIIB — ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED GLP-1 AGENTS ONLY (Complete this section only for PA requests for non-preferred GLP-1 agents. Prior authorization requests for non-preferred GLP-1 agents must be submitted on paper.)**

30. In the last year, has the member taken the maximum dose of Byetta for at least three consecutive months and failed to achieve at least a 0.5 percent decrease in HbA1c?       Yes       No

If yes, list the dates Byetta was taken, the dose of Byetta, and directions for use. In addition, list the member's HbA1c values prior to starting Byetta, the member's HbA1c values during treatment with Byetta, and the dates the values were measured in the space provided.

31. Has the member taken Byetta in the last year and experienced a clinically significant adverse drug reaction?       Yes       No

If yes, list the dates Byetta was taken, the dose of Byetta, directions for use, and specific details about the clinically significant adverse drug reaction in the space provided.

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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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32. National Drug Code (11 Digits)

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

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34. NPI

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35. 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.)

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36. Place of Service

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37. Assigned PA Number

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38. Grant Date

39. Expiration Date

40. Number of Days Approved

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**SECTION V — AUTHORIZED SIGNATURE**

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41. **SIGNATURE** — Prescriber

42. Date Signed

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**SECTION VI — ADDITIONAL INFORMATION**

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

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