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 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 ID 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 – Prescriber

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

12. Telephone Number – Prescriber

SECTION III – CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Is the member 18 years of age or older?	☐ Yes	☐ No
15. Does the member have type 2 diabetes mellitus?	☐ Yes	☐ No
16. Does the member currently have or is there a history of pancreatitis?	☐ Yes	☐ No
17. Does the member currently have or is there a history of gastroparesis?	☐ Yes	☐ No

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

%

19. Date Member's HbA1c Measured (Within the Past Three Months)

/ /

Month Date Year

Continued

SECTION III – CLINICAL INFORMATION (Continued)

20. List the member's current GLP-1 therapy or check "none" if appropriate.

❑ None

Drug Name _____ Dose _____ Start Date _____

21. List the member's previous GLP-1 therapy and reason(s) for discontinuation or check "none" if appropriate.

❑ None

Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

Drug Name _____ Dose _____ Dates Taken _____

Reason for Discontinuation _____

22. Prior authorization requests must include detailed documentation regarding why the member is unable to take or has previously discontinued **at least two** of the following GLP-1 treatments: Bydureon®, Byetta®, and Victoza®. The following will **not** be considered as criteria to support the need for a non-preferred GLP-1 agent:
    - Non-adherence to previous GLP-1 treatment
    - Member or prescriber preference for the use of a non-preferred GLP-1 agent
    - Member or prescriber preference for a less frequent dosing schedule

1. Bydureon® Documentation

2. Byetta® Documentation

3. Victoza® Documentation

Continued

SECTION V – AUTHORIZED SIGNATURE

23. **SIGNATURE** – Prescriber	24. Date Signed

SECTION VI – ADDITIONAL INFORMATION

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

Reset Form