DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00238 (07/2018)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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 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. Phone 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 pancreatitis or have a history of pancreatitis?	❑ Yes	❑ No
17. Does the member currently have gastroparesis or have a history of gastroparesis?	❑ Yes	❑ No

18. Indicate the member's most current hemoglobin A1c (HbA1c). _____ _____. _____ %	19. Date Member's HbA1c Measured (Within the Past Six Months) _____ _____ / _____ _____ / _____ _____ _____ _____ Month Date Year

Continued

DT-PA091-091

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. PA 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: exenatide (Bydureon/Byetta), Trulicity, and Victoza. The following will **not** be considered as criteria to support the need for a non-preferred GLP-1 agent:
    - Nonadherence 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

    ForwardHealth will only consider use of exenatide (Bydureon/Byetta) as one of the preferred GLP-1 agent treatments.

    1. Exenatide (Bydureon/Byetta) Documentation

    2. Trulicity Documentation

    3. Victoza Documentation

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.