DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00238 (07/2020)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR GLUCAGON-LIKE PEPTIDE (GLP-1) AGENTS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Glucagon-Like Peptide (GLP-1) Agents Instructions, F-00238A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment 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. Indicate the member's most current hemoglobin A1c.

_____ _____. _____ %

18. Date Member's Hemoglobin A1c Measured (Within the Past Six Months)

_____ _____ / _____ _____ / _____ _____ _____ _____
Month Date Year

DT-PA091-091

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

❑ None

Drug Name _____ Dose _____ Start Date _____

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

❑ None

Drug Name _____ Dose _____ Date(s) Taken _____

Reason for Discontinuation _____

Drug Name _____ Dose _____ Date(s) Taken _____

Reason for Discontinuation _____

Drug Name _____ Dose _____ Date(s) Taken _____

Reason for Discontinuation _____

21. 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 Pen/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 fear of needles
- Member or prescriber preference for the use of an oral agent
- Member or prescriber preference for the use of a non-preferred GLP-1 agent
- Member or prescriber preference for a less frequent dosing schedule

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

1. Exenatide (Bydureon Pen/Byetta) Documentation

2. Trulicity Documentation

3. Victoza Documentation

SECTION V – AUTHORIZED SIGNATURE	
22. **SIGNATURE** – Prescriber	23. Date Signed

SECTION VI – ADDITIONAL INFORMATION

24. 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