DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00238 (07/2023)

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

FORWARDHEALTH

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

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Hypoglycemics, Glucagon-Like Peptide (GLP-1) Agents Instructions, F-00238A. Prescribers 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 Hypoglycemics, Glucagon-Like Peptide (GLP-1) Agents form signed and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy 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. Address – Prescriber (Street, City, State, Zip+4 Code)

11. Phone Number – Prescriber	12. National Provider Identifier – Prescriber

SECTION III – CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Is the non-preferred drug being prescribed in a manner consistent with the Food and Drug Administration-approved product labeling? ☐ Yes ☐ No

15. Does the member have type 2 diabetes mellitus? ☐ Yes ☐ No

DT-PA091-091

16. Indicate the member's most recent hemoglobin A1c (HbA1c).

_____ _____ _____ %

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

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

18. List the member's current hypoglycemics, GLP-1 therapy, or check None if appropriate.

❑ None

Drug Name _____ Dose _____ Start Date _____

19. List the member's previous hypoglycemics, GLP-1 therapy and the 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 _____

20. PA requests must include detailed documentation regarding why the member is unable to take or has previously discontinued **at least two** of the preferred hypoglycemics, GLP-1 treatments.

1. Byetta Documentation

2. Trulicity Documentation

3. Victoza Documentation

SECTION IV – AUTHORIZED SIGNATURE	
21. **SIGNATURE** – Prescriber	22. Date Signed

SECTION V – ADDITIONAL INFORMATION

23. 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