**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-00238 (07/2024)

**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](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.

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| **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    **Note: Supporting clinical information, a copy of the member’s current medical records, and a current hemoglobin A1c (HbA1c) lab report must be submitted with all PA requests.** | |
| 14. Is the non-preferred drug being prescribed in a manner consistent  Yes  No with the Food and Drug Administration-approved product labeling? | |
| 15. Does the member have type 2 diabetes mellitus?  Yes  No | |
| 16. Indicate the member’s most recent 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. Has the member taken the maximum dose of **at least one** preferred hypoglycemics, GLP-1 agent(s) for at least three consecutive months and experienced an unsatisfactory therapeutic response in glycemic control or experienced a clinically significant adverse drug reaction?  Yes  No  If yes, check the preferred hypoglycemics, GLP-1 agent(s) the member has taken and provide specific details regarding the member’s unsatisfactory therapeutic response in glycemic control or clinically significant adverse drug reaction. The drug dose, approximate date(s) taken, and the reason(s) for discontinuing must also be documented. | | |
| Byetta Dose       Date(s) Taken  Description of Treatment Response and Reason(s) for Discontinuing | | |
| Trulicity Dose       Date(s) Taken  Description of Treatment Response and Reason(s) for Discontinuing | | |
| Victoza Dose       Date(s) Taken  Description of Treatment Response and Reason(s) for Discontinuing | | |

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| **SECTION IV – AUTHORIZED SIGNATURE** | |
| 20. **SIGNATURE** – Prescriber | 21. Date Signed |
| **SECTION V – ADDITIONAL INFORMATION** | |
| 22. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here. | |