**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

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

F-00238 (07/2025)

**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 (the 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 [ ]  Nowith 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.[ ]  NoneDrug Name       Dose       Start Date       |
| 19. Members are required to have taken the maximum dose of **at least two** preferred hypoglycemics, GLP-1 agents for **at least three** consecutive months and experienced an unsatisfactory therapeutic response in glycemic control or experienced a clinically significant adverse drug reaction.Indicate the preferred hypoglycemics, GLP-1 agents the member has taken and provide specific details regarding the member’s response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form. 1. Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuing       |
| 2. Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuing       |
| 3. Drug Name       Dose       Dates Taken      Description of Treatment Response and Reason(s) for Discontinuing       |
| **SECTION IV – AUTHORIZED SIGNATURE** |
| 20. **SIGNATURE** – Prescriber      | 21. Date Signed      |

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| **SECTION V – ADDITIONAL INFORMATION** |
| 22. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the requested drug may be included here.      |