**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  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. 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. |