DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00238 (07/2025)

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 (the 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

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 with the Food and Drug Administration-approved product labeling?	❑ Yes	❑ No
15. Does the member have type 2 diabetes mellitus?	❑ Yes	❑ No

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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

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.

Reset Form