HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS PRIOR AUTHORIZATION FORM

PRIOR AUTHORIZATION REQUEST INFORMATION



(form effective 1/8/2024)

Fax to PerformRx $^{\text{SM}}$ at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

Name of five contact:	\square New request \square Re	newal request	Total # of pages:						
Reliant name	Name of office contact:			Contact's phone number:			LTC facility contact/phone:		
Reliant name	PATIENT INFORM	ATION							
Residence in the content of the cont				Pat	ient ID #:			DOB:	
PRESCRIBER INFORMATION Prescriber name: Specialty: She defines: Sucial #: City/stata/zip: Phone: Fax: CLINICAL INFORMATION Drug requested: Deagnosis (submit documentation): Camplete all sections that apply to the beneficiary and this request. Check all that apply and submit documentation for each item. INITIAL REQUESTS 1. For a non-preferred GLP-1 RECEPTOR AGOINST for the treatment of DBESITY: The dear distal of these a contraindication or an intolineance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.) In the beneficiary's sugnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.) The beneficiary is sugnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.) The beneficiary is all years of age or offer: Pre-treatment weight - then or equal 27 kg/m2 and less than 30 kg/m2 and at less on or the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the following weight-related comorbidities: open the state of the	Street address:			'				'	
Prescriber name: Specific S	Apt #:	City/state/zip:				Phone:			
Specially: Street address:	PRESCRIBER INFO	ORMATION							
Street address: Suite #: City/state/zip: Phone: Fax:									
Suite #: City/state/zip: Fax:	Specialty:				NPI: State license #:				
Phone: Fax: CLINICAL INFORMATION	Street address:				'				
Complete all sections: Quantity: Refills:	Suite #:	City/state/zip:							
Dose and directions: Diagnosis (submit documentation): Complete all sections that apply to the beneficiary and this request.	Phone: Fax:								
Dose and directions: Diagnosis (submit documentation): Complete all sections that apply to the beneficiary and this request.	CLINICAL INFORM	1ATION		'					
Diagnosis (submit documentation): Complete all sections that apply to the beneficiary and this request. Check all that apply and submit documentation for each item. INITIAL REQUESTS							Strength:		
Complete all sections that apply to the beneficiary and this request. Check all that apply and submit documentation for each item. INITIAL REQUESTS 1. For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY: Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.) List preferred medications tried: Attestation from the prescriber: The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity The beneficiary is 18 years of age or older: Pre-treatment weight: Pr	Dose and directions:						Quantity	:	Refills:
Check all that apply and submit documentation for each item. INITIAL REQUESTS 1. For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY: Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.) List preferred medications tried: List preferred dLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary is administry. List preferred medications tried: List preferred medicati	Diagnosis (submit documentation):							Dx code (required):	
For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY: Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.) List preferred medications tried: Attestation from the prescriber: The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity The beneficiary is 18 years of age or older: Pre-treatment weight:									
Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.)	INITIAL REQUEST	S							
☐ other (list):	☐ Tried and failed or h the beneficiary's dia List preferred medic ☐ Attestation from tt ☐ The beneficiary is ☐ The beneficiary is ☐ Pre-treatment weig ☐ Has a BMI greate ☐ dyslipidemia ☐ hypertension ☐ metabolic syn ☐ obstructive sle ☐ prediabetes ☐ type 2 diabete ☐ other (list): ☐ Is a candidate fo and has at least ☐ dyslipidem ☐ hypertensi ☐ metabolic ☐ obstructive ☐ obstructive ☐ obstructive ☐ prediabete	as a contraindication or an agnosis or indication (Refer cations tried: the prescriber: was counseled about lifesty 18 years of age or older: th: this pre-than or equal to 30 kg/mer than or equal 27 kg/m2 drome eep apnea ss r treatment based on degration one of the following weighnia on syndrome e sleep apnea	n intolerance to the preferred Gr to https://papdl.com/preferred Gr to htt	GLP-1 receptor ag rred-drug-list for diffications such as t least one of the	a list of pr	referred and non-preferred diet and increased physica	GLP-1 re	ceptor agonists.)	medically accepted for
	☐ The beneficiary is Pre-treatment BMI:	less than 18 years of age Pre-tre	eatment BMI z-score:	hased on current	CDC chart	s			

INITIAL REQUESTS (continued)						
2. For the treatment of ALL OTHER diagnoses:						
☐ Request is for a non-preferred GLP-1 receptor agonist:						
\square Tried and failed or has a contraindication or an intolerance f	o the preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists that are approved or medically					
accepted for the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/						
Enhancers GLP-1 receptor agonists.)						
List preferred medications tried:						
☐ Request is for a non-preferred <u>DPP-4 inhibitor</u> :						
☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors that are approved or medically accepted for						
the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers						
DPP-4 inhibitors.)						
List preferred medications tried:						
□ Request is for non-preferred Symlin (pramlintide)						
RENEWAL REQUESTS						
☐ For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment	atment of ORESITY:					
☐ Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for						
the beneficiary's diagnosis or indication (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.)						
List preferred medications tried:						
☐ The dose of the requested medication is currently being titrated						
☐ The beneficiary is experiencing clinical benefit with the requested medication						
☐ Attestation from the prescriber:						
☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity						
☐ The beneficiary is <u>18 years of age or older</u> :						
Pre-treatment weight:	•					
☐ The beneficiary is less than 18 years of age:	Current DMI.					
Pre-treatment BMI:	_ Current PML a coord					
Pre-treatment BMI z-score: Current BMI z-score: The beneficiary is being treated for a diagnosis OTHER THAN OBESITY.						
- The senenciary to sening a eacea for a diagnicolo ettilla titrat object in						
PLEASE FAX COMPLETED FORM WITH REQUI	RED CLINICAL DOCUMENTATION					

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.

Prescriber signature:

Date: