Iowa Department of Human Services

Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for pre-filled insulin pens as designated on the Preferred Drug List (PDL). For pre-filled insulin pens requiring PA where the requested insulin is available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin (not applicable for pediatric patients), and 2) There is no caregiver available to provide assistance, and 3) Patient does not reside in a long-term care facility, and 4) For requests for non-preferred pre-filled pens, patient has documentation of a previous trial and therapy failure with a preferred pre-filled insulin pen within the same class (i.e. rapid, regular or basal). For pre-filled insulin pens requiring PA where the requested insulin is not available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) Preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular, or basal) or clinical rationale as to why the patient cannot use a preferred insulin agent, and 2) Non-preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular or basal). 3) Requests for Toujeo will require clinical rationale as to why the patient cannot use Lantus and patient must be using a minimum of 100 units of Lantus per day.

Preferred (no PA required)

☐ Fiasp FlexTouch ☐ Lantus SoloSTAR ☐ Levemir FlexTouch

☐ NovoLog FlexPen/PenFill ☐ Novolog Mix FlexPen ☐ Tresiba FlexTouch

PA Required:

Non-Preferred (available in vial)

☐ Admelog SoloSTAR
☐ Apidra SoloSTAR
☐ Humalog KwikPen
☐ Humalog Mix 50/50 Pen
☐ Humulin Mix 75/25 Pen
☐ Humulin N KwikPen
☐ Humulin R KwikPen
☐ Humulin 70/30 KwikPen

Non-Preferred (not available in vial)

☐ Basaglar KwikPen
☐ Toujeo SoloStar

Strength _____ **Number of Units** _____ **How Often** _____ **Number of Cartridges/Pens/PenFills (circle requested item)** _____

Diagnosis: _____

☐ **Requests for insulin agents available in a vial:**

What visual or physical conditions limit the patient's ability to prepare their own syringes (adult patients only)?

_____

Does the patient lack capable assistance residing with them? ☐ Yes ☐ No

Does the patient reside in a long-term care facility? ☐ Yes ☐ No

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Requests for a non-preferred pre-filled insulin pen, document preferred pre-filled insulin pen trial within the same class:

Drug Name and Dosage Instructions:_____ Trial start date: _____Trial end date:____
Failure Reasons: _____
_____

☐ **Requests for insulin agents not available in a vial:**

Document Preferred Insulin Trial in same class as requested agent:

Drug Name and Dosage Instructions:_____ Trial start date: _____Trial end date:____
Failure Reasons: _____
_____

Toujeo:

Patient's current daily Lantus dose: _____

Clinical rationale as to why patient cannot use Lantus: _____
_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*