Iowa Department of Human Services

Request for Prior Authorization
GLP-1 Agonist/Basal Insulin Combinations

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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 is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met:

1) A diagnosis of Type 2 Diabetes Mellitus, and
2) Patient is 18 years of age or older; and
3) The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated; and
4) Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and
5) Will not be used concurrently with prandial insulin; and
6) Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and
7) Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of:
   a) Soliqua below 15 units or over 60 units, or
   b) Xultophy persistently below 16 units or over 50 units.

Non-Preferred

☐ Soliqua ☐ Xultophy

Strength	**Dosage Instructions**	**Quantity**	**Day's Supply**

Diagnosis: _____

Most Recent HgbA1C Level: _____ Date this level was obtained: _____

Metformin Trial: Trial start date: _____ Trial end date: _____ Trial dose: _____

Reason for failure: _____

Medical or contraindication reason to override trial requirements: _____

_____

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Preferred GLP-1 Receptor Agonist Trial: Drug name/dose:_____

Trial start date:_____ Trial end date:_____

Reason for failure:_____

Preferred Long-Acting Insulin Trial: Drug name/dose:_____

Trial start date:_____ Trial end date:_____

Reason for failure:_____

Clinical rationale as to why patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently:_____

_____

Is prandial insulin being used concurrently? ☐ Yes ☐ No

Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of:

☐ Soliqua – below 15 units or over 60 units ☐ Yes ☐ No

☐ Xultophy – persistently below 16 units or over 50 units ☐ Yes ☐ No

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.*