**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-00238 (07/2023)

**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 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 | |
| 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 | |
| 16. Indicate the member’s most recent hemoglobin A1c (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. List the member’s previous hypoglycemics, GLP-1 therapy and the reason(s) for discontinuation, or check None if appropriate.  None  Drug Name       Dose       Dates Taken  Reason for Discontinuation  Drug Name       Dose       Dates Taken  Reason for Discontinuation  Drug Name       Dose       Dates Taken  Reason for Discontinuation | | |
| 20. PA requests must include detailed documentation regarding why the member is unable to take or has previously discontinued **at least two** of the preferred hypoglycemics, GLP-1 treatments. | | |
| 1. Byetta Documentation | | |
| 2. Trulicity Documentation | | |
| 3. Victoza Documentation | | |

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| **SECTION IV – AUTHORIZED SIGNATURE** | |
| 21. **SIGNATURE** – Prescriber | 22. Date Signed |
| **SECTION V – ADDITIONAL INFORMATION** | |
| 23. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here. | |