DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00238 (07/2024)

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 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

DT-PA091-091

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. Has the member taken the maximum dose of **at least one** preferred hypoglycemics, GLP-1 agent(s) for at least three consecutive months and experienced an unsatisfactory therapeutic response in glycemic control or experienced a clinically significant adverse drug reaction?

❑ Yes ❑ No

If yes, check the preferred hypoglycemics, GLP-1 agent(s) the member has taken and provide specific details regarding the member's unsatisfactory therapeutic response in glycemic control or clinically significant adverse drug reaction. The drug dose, approximate date(s) taken, and the reason(s) for discontinuing must also be documented.

❑ Byetta Dose _____ Date(s) Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

❑ Trulicity Dose _____ Date(s) Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

❑ Victoza Dose _____ Date(s) 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 drug requested may be included here.

Reset Form