

FORWARDHEALTH
**PRIOR AUTHORIZATION DRUG ATTACHMENT
FOR HYPOGLYCEMICS, INSULINS LONG-ACTING**

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Hypoglycemics, Insulins Long-Acting Instructions, F-01749A. 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, Insulins Long-Acting 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 – ALL PA REQUESTS

13. Diagnosis Code and Description

Note: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.

14. List the member's current insulin treatment regimen or check None if appropriate.

None

Insulin _____ Dose / Dose Regimen _____ Start Date _____

Insulin _____ Dose / Dose Regimen _____ Start Date _____

Insulin _____ Dose / Dose Regimen _____ Start Date _____



SECTION IV – CLINICAL INFORMATION – INITIAL PA REQUESTS ONLY

15a. Has the member previously used insulin glargine U-100? Yes No

If yes, provide details regarding how the member's insulin glargine U-100 treatment regimen was adjusted to optimize glycemic control and the approximate dates used. Include details regarding short-acting insulin if used in conjunction with insulin glargine U-100. In addition, provide details regarding the member's hemoglobin A1c (HbA1c) and fasting blood glucose (FBG) readings along with approximate dates.

15b. Has the member experienced symptomatic hypoglycemia while using insulin glargine U-100? Yes No

If yes, provide details regarding the frequency of hypoglycemic episodes, the blood sugar readings, when the last symptomatic hypoglycemic event occurred, and what medical intervention was required. What insulin adjustment options were utilized to decrease hypoglycemic episodes?

16a. List the glycemic treatment goals the prescriber has established for the member such as HbA1c and FBG.

16b. List the member's proposed insulin treatment regimen, including the non-preferred hypoglycemics, insulins long-acting drug.

Insulin _____ Dose / Dose Regimen _____

Insulin _____ Dose / Dose Regimen _____

Insulin _____ Dose / Dose Regimen _____

SECTION V – CLINICAL INFORMATION – RENEWAL PA REQUESTS ONLY

17. Has the member demonstrated a clinical improvement since starting the non-preferred hypoglycemics, insulins long-acting drug? Yes No

If yes, provide specific examples of how the member's diabetes management has improved as a result of using a non-preferred hypoglycemics, insulins long-acting drug. A copy of the member's medical records must be submitted that demonstrate an improvement in the member's glycemic control. Examples include a decrease in HbA1c, improved FBG, and decreased hypoglycemia.

SECTION VI – AUTHORIZED SIGNATURE

18. SIGNATURE – Prescriber

19. Date Signed

SECTION VII – ADDITIONAL INFORMATION

20. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.
