Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pharmacy Benefits Prior Authorization Help Desk
DPP-4 Inhibitors for treatment of DM2 Prior Authorization (PA)

Instructions:

This form is used by participating providers for coverage of **Dipeptidyl peptidase-4 (DPP-4) Inhibitors for Type 2 diabetes mellitus (DM2).** Please complete and fax this form back to Kaiser Permanente within 24 hours at fax: 1-866-331-2104. If you have any questions or concerns please call 1-866-331-2103. **Request will not be considered unless form is completely filled out. KP-MAS Formulary can be found at www.providers.kp.org/mas/formulary.html**

A. Patient Information

Patient Name:	Kaiser ID (if available):
Patient Date of Birth:	Patient Phone Number:

B. Provider Information

Provider Name:	Provider Address:
Provider NPI:	Provider Phone Number:
Provider Fax Number:	

Please check the box that applies:

□ Standard Review (72 hours)

□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

C. Pharmacy Information

Pharmacy Name:	NABP/NPI #:
Pharmacy Phone Number:	Pharmacy Fax Number:

D. Drug Information

Drug Name and Strength:	Quantity and Days Supply:
Directions (SIG):	Date Requested:

E. LENGTH OF AUTHORIZATION : 1 Year

1. Does patient have diagnosis of diabetes mellitus type 2?
☐ Yes, please go to question 2 ☐ No [If no, then no further questions required]

2. Is patient over 18 years old?
☐ Yes, please go to question 3 ☐ No [If no, then no further questions required]

3. Does patient have an A1c over 7% AND lab results within 90 days?
☐ Yes, answer and go to question 4 ☐ No [If no, then no further questions required]
A1c goal____% Value__% Date_____

4. Does patient have any intolerance, contraindications or hypersensitivity reactions to DPP4 inhibitors?
☐ No, please go to question 5 ☐ Yes [If yes, then no further questions required]

5. Is this request for the preferred DPP4 inhibitor, linagliptin (Tradjenta)?
☐ Yes, please go to question 6 ☐No If No, provide medical necessity for non-formulary DPP4 inhibitor and complete the rest of the form: _____
_____

6. Patient has demonstrated adequate trial (90 days) and adherence to ALL formulary oral medications at maximum tolerated dose unless contraindicated?
☐ Yes, please go to question 7 ☐ No (If no, recommend trial of listed formulary agents, no further questions needed)
Select formulary medication tried ☐ metformin ☐ glipizide ☐ pioglitazone ☐ other (please describe) _____
_____

7. Does patient have contraindication to:
☐ No, please go to question 8 ☐ metformin ☐ sulfonylurea ☐ pioglitazone
If yes, please describe: _____

8. Patient is candidate for insulin therapy
☐ Yes, please continue to section F ☐ No (If no, please provide reason) _____
_____

Requests for Renewal (adults)
Renewal is contingent upon prescriber affirmation of patient achieving personal A1c goal, please document: _____
_____

F. Addition Information

Is there any additional information that would help in the decision making process? If so please describe.

G. Provider Sign off

Provider Signature:	Date: