Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pharmacy Benefits Prior Authorization Help Desk
GLP-1 receptor agonist for treatment of DM2 Prior Authorization (PA)

Instructions:

This form is used by participating providers for coverage of **Glucagon-like peptide-1 (GLP-1) receptor agonist 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, A1c goal_____% Value_____% Date_____
☐ No [If no, then no further questions required]

4. Does patient have any intolerance or contraindications to GLP1 receptor agonists including: risk of thyroid C-cell tumors (observed in rat studies), multiple endocrine neoplasia syndrome type 2 (MEN2), history or family history of medullary thyroid carcinoma (MTC), or hypersensitivity reactions to GLP1 agonists?
☐ No, please go to question 5
☐ Yes [If yes, then no further questions required]

5. Is this request for the preferred GLP1 receptor agonist, exenatide extended-release (Bydureon BCise)?
☐ Yes, please go to question 6
☐No (If no, please provide medical necessity statement for non-formulary GLP1 receptor agonist and complete the rest of the form) _____
_____

6. Does patient have severe renal function (CrCl <30 ml/min)?
☐ No, please go to question 7
☐ Yes [If yes, then no further questions required]

7. Does patient have active or recent pancreatitis?
☐ No, please go to question 8
☐ Yes [If yes, then no further questions required]

8. Patient has demonstrated adequate trial (90 days) and adherence to ALL formulary oral medications at maximum tolerated dose unless contraindicated?
☐ Yes, select medication tried ☐ metformin ☐ glipizide ☐ pioglitazone ☐ other (please describe): _____
☐ No, please provide explanation _____

9. Is patient currently taking:
☐ metformin ☐ sulfonylurea ☐ pioglitazone ☐basal insulin ☐ other (please describe): _____

10. Does patient have contraindication to: ☐ metformin ☐ sulfonylurea ☐ pioglitazone
☐ No
☐ Yes, please describe: _____

11. Patient is currently using prandial insulin?
☐ No, please go to section F
☐ Yes, please note, concurrent use of GLP1 agonist and prandial insulin has not been studied and cannot be recommended

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: