HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)

Keystone First Community HealthChoices | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	NPI:	State license #:
Street address:		
Suite #:	City/state/zip:	
Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose and directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code *(required)*:	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL REQUESTS

1. For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:

☐ Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred GLP-1 receptor agonists.)
List preferred medications tried:_____

☐ **Attestation from the prescriber:**
- ☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐ **The beneficiary is 18 years of age or older:**
Pre-treatment weight:_____ Pre-treatment BMI: _____
- ☐ Has a BMI greater than or equal to 30 kg/m2
- ☐ Has a BMI greater than or equal 27 kg/m2 and less than 30 kg/m2 and at least one of the following weight-related comorbidities:
  - ☐ dyslipidemia
  - ☐ hypertension
  - ☐ metabolic syndrome
  - ☐ obstructive sleep apnea
  - ☐ prediabetes
  - ☐ type 2 diabetes
  - ☐ other (list):_____
- ☐ Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for beneficiary's ethnicity, etc. and has at least one of the following weight-related comorbidities:
  - ☐ dyslipidemia
  - ☐ hypertension
  - ☐ metabolic syndrome
  - ☐ obstructive sleep apnea
  - ☐ prediabetes
  - ☐ type 2 diabetes
  - ☐ other (list):_____

☐ **The beneficiary is less than 18 years of age:**
Pre-treatment BMI:_____ Pre-treatment BMI z-score:_____
- ☐ Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

INITIAL REQUESTS (continued)

2. For the treatment of ALL OTHER diagnoses:

☐ **Request is for a non-preferred GLP-1 receptor agonist:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists.)
List preferred medications tried:_____

☐ **Request is for a non-preferred DPP-4 inhibitor:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.)
List preferred medications tried:_____

☐ **Request is for non-preferred Symlin (pramlintide)**

RENEWAL REQUESTS

☐ **For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred GLP-1 receptor agonists.)
List preferred medications tried:

_____

☐ The dose of the requested medication is currently being titrated

☐ The beneficiary is experiencing clinical benefit with the requested medication

☐ **Attestation from the prescriber:**

☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐ **The beneficiary is 18 years of age or older:**

Pre-treatment weight: _____ Current weight: _____

☐ **The beneficiary is less than 18 years of age:**

Pre-treatment BMI: _____ Current BMI: _____

Pre-treatment BMI z-score: _____ Current BMI z-score: _____

☐ **The beneficiary is being treated for a diagnosis OTHER THAN OBESITY.**

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: