HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS PRIOR AUTHORIZATION FORM

(form effective 9/2/2024)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:
Dose/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 requests for SYMLIN (pramlintide),** submit chart documentation supporting the use of Symlin.

2. **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:_____

3. **For a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST:**
   ☐ The beneficiary is being treated for or has a diagnosis of DIABETES
   ☐ The beneficiary is being treated for OVERWEIGHT or OBESITY and:
   ☐ **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 and:**
   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:
   ☐ cardiovascular disease ☐ obstructive sleep apnea
   ☐ dyslipidemia ☐ prediabetes
   ☐ hypertension ☐ type 2 diabetes
   ☐ metabolic syndrome ☐ 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:
   ☐ cardiovascular disease ☐ obstructive sleep apnea
   ☐ dyslipidemia ☐ prediabetes
   ☐ hypertension ☐ type 2 diabetes
   ☐ metabolic syndrome ☐ other (list): _____
   ☐ **The beneficiary is less than 18 years of age and:**
   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

☐ **For a NON-PREFERRED Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST** *(Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist.):*

- ☐ **For the treatment of OVERWEIGHT OR OBESITY:**
  - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
    - ☐ Ozempic
    - ☐ Trulicity
    - ☐ Victoza
  - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
    - ☐ Saxenda
    - ☐ Wegovy
    - ☐ Zepbound
- ☐ **For the treatment of ALL OTHER diagnoses:**
  - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
    - ☐ Ozempic
    - ☐ Trulicity
    - ☐ Victoza

RENEWAL REQUESTS

☐ **For a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:**

- ☐ **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: _____
- ☐ At least **one** of the following:
  - ☐ The dose of the requested medication is currently being titrated
  - ☐ The beneficiary experienced a percent reduction in body weight (for beneficiaries 18 years of age or older) or BMI or BMI z-score (for beneficiaries less than 18 years of age) that is consistent with the recommended cutoff in the FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose
  - ☐ The beneficiary experienced an improvement in degree of adiposity or waist circumference from baseline
  - ☐ The beneficiary experienced clinical benefit with the requested medication in at least one weight-related comorbidity from baseline, such as dyslipidemia, hypertension, type 2 diabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.
- ☐ **Attestation from the prescriber:**
  - ☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐ **Request is for a NON-PREFERRED Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST**
*(Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred drugs in this class.):*

- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Ozempic
  - ☐ Trulicity
  - ☐ Victoza
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Saxenda
  - ☐ Wegovy
  - ☐ Zepbound

☐ **The beneficiary is being treated for a diagnosis OTHER THAN OVERWEIGHT OR OBESITY or the request is for a DPP-4 INHIBITOR or SYMLIN (pramlintide).**

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: