iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ANTI-DIABETIC NON-INSULIN AGENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for select preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and

2. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and

3. Requests for non-preferred antidiabetic, non-insulin agents subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Additionally, requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with at least 3 preferred agents from 3 different drug classes at maximally tolerated doses.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Requests for weight loss are not a covered diagnosis of use and will be denied.

Preferred DPP-4 Inhibitors and Combinations (No PA Required)
- ☐ Janumet
- ☐ Janumet XR
- ☐ Januvia
- ☐ Jentadueto
- ☐ Tradjenta

Non- Preferred DPP-4 Inhibitors and Combinations
- ☐ Alogliptin
- ☐ Alogliptin-Metformin
- ☐ Alogliptin-Pioglitazone
- ☐ Glyxambi
- ☐ Jentadueto XR
- ☐ Kazano
- ☐ Kombiglyze XR
- ☐ Nesina
- ☐ Onglyza
- ☐ Oseni
- ☐ Saxagliptin
- ☐ Saxagliptin-Metformin ER
- ☐ Sitagliptin
- ☐ Sitagliptin-Metformin
- ☐ Zituvio
- ☐ Trijardy XR

Preferred GLP-1 RAs (PA required)
- ☐ Bydureon
- ☐ Ozempic
- ☐ Trulicity
- ☐ Victoza

Non-Preferred GLP-1 RAs and Combinations
- ☐ Adlyxin
- ☐ Bydureon BCise
- ☐ Byetta
- ☐ Liraglutide
- ☐ Mounjaro
- ☐ Rybelsus

Preferred SGLT2 Inhibitors and Combinations (No PA Required)
- ☐ Farxiga
- ☐ Jardiance
- ☐ Synjardy
- ☐ Xigduo XR

Non-Preferred SGLT2 Inhibitors and Combinations
- ☐ Dapagliflozin
- ☐ Dapagliflozin/Metformin
- ☐ Invokamet
- ☐ Invokamet XR
- ☐ Invokana
- ☐ Qtern
- ☐ Segluromet
- ☐ Steglatro
- ☐ Steglujan
- ☐ Synjardy XR

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

Diagnosis: _____

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ANTI-DIABETIC NON-INSULIN AGENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Type 2 Diabetes Mellitus**

Most recent A1C Level:_____ Date this level was obtained: _____

Requests for Non-Preferred Drugs:

Preferred Trial 1: Drug Name/Dose: _____

Trial start date:_____ Trial end date: _____

Reason for Failure: _____

Preferred Trial 2: Drug Name/Dose: _____

Trial start date:_____ Trial end date: _____

Reason for Failure: _____

Preferred Trial 3: Drug Name/Dose: _____

Trial start date:_____ Trial end date: _____

Reason for Failure: _____

_____

Medical or contraindication reason to override trial requirements: _____

_____

☐ **Other diagnosis:** _____

Trial of preferred drug in the same class: Drug Name/Dose: _____

Trial start date:_____ Trial end date: _____

Reason for Failure: _____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*