GLUCAGON-LIKE PEPTIDE-1 (GLP-1)
PRIOR AUTHORIZATION
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date: _____**

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

If requesting insulin, please note that Novolin and Novolog are the preferred insulin products.

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____

Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No

If yes: Is the current use with samples? ..... ☐ Yes ☐ No

Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g. contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max): __

_____

_____

Please select the patient's diagnosis and answer the corresponding question(s):

☐ **Weight Loss**

Is the requested agent being used primarily for weight loss? ..... ☐ Yes ☐ No

☐ **Type 2 Diabetes Mellitus**

Is the requested agent being used for a diagnosis of type 2 diabetes mellitus? **Please note, medical records are required.** ..... ☐ Yes ☐ No

Please continue to the next page.

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Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

Has the patient tried and had an inadequate response to an agent containing metformin or insulin? ☐ Yes ☐ No

If no: Does the patient have an intolerance or hypersensitivity to metformin or insulin? ☐ Yes ☐ No

If yes: Please explain intolerance/hypersensitivity: _____

_____

If no: Does the patient have an FDA labeled contraindication to BOTH metformin and insulin? ☐ Yes ☐ No

If yes: Please explain contraindication: _____

_____

If no: Does the patient have a diagnosis of type 2 diabetes with or at high risk for atherosclerotic cardiovascular disease, heart failure, or chronic kidney disease? ☐ Yes ☐ No

Will the patient be using the requested agent in combination with a DPP-4 agent containing agent for the requested indication? ☐ Yes ☐ No

Will the patient be using the requested agent in combination with another GLP-1? ☐ Yes ☐ No

If currently treated with the requested medication: Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? Please note, documentation of a health plan paid claim for the medication during the 90 days immediately before the request must be submitted. ☐ Yes ☐ No

For **Bydureon, Mounjaro, Ozempic, Rybelsus, or Trulicity** requests:

Has the patient been treated with the preferred requested agent, not including samples, within the past 90 days**?** ☐ Yes ☐ No

If yes: Is the patient at risk if therapy is changed? ☐ Yes ☐ No

If yes: Please explain the risk if therapy with the preferred agent is discontinued: _____

_____

For **Adlyxin, Byetta, Liraglutide, or Victoza** requests:

Has the patient tried and had an inadequate response to semaglutide (Ozempic or Rybelsus) after at least a 90-day trial of therapy? ☐ Yes ☐ No

If yes: Please specify agent and dates of trial(s): _____

_____

If no: does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to semaglutide (Ozempic or Rybelsus)? **Please note, medical records/documentation are required.** ☐ Yes ☐ No

Has the patient tried and had an inadequate response to dulaglutide (Trulicity) after at least a 90-day trial of therapy? ☐ Yes ☐ No

If yes: Please specify agent and dates of trial(s): _____

_____

If no: does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to dulaglutide (Trulicity)? **Please note, medical records/documentation are required.** ☐ Yes ☐ No

Has the patient tried and had an inadequate response to tirzepatide (Mounjaro) after at least a 90-day trial of therapy? ☐ Yes ☐ No

If yes: Please specify agent and dates of trial(s): _____

_____

If no: does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to tirzepatide (Mounjaro)? **Please note, medical records/documentation are required.** ☐ Yes ☐ No

☐ **Other** (Please specify): _____

Please continue to the next page.

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Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183

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