Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antihyperglycemics, DPP-4 Inhibitors, DPP-4 Combination (Metformin, Thiazolidinedione)
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antihyperglycemics, DPP-4 Inhibitors, DPP-4 Combination (Metformin, Thiazolidinedione).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

Medications:

• ALOGLIPTIN-PIOGLITAZONE • ALOGLIPTIN BENZOATE • ALOGLIPTIN-METFORMIN	• JANUVIA • JANUMET, JANUMET XR • ONGLYZA

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Does the member have a diagnosis of type 2 diabetes mellitus?
   □ No □ Yes

2. Is the member ≥18 years old?
   □ No □ Yes

3. Is the HbA1c within 2% above goal (as per ADA guidelines) within 90 days of the PA request *(Note: if A1c is >2% above goal, insulin therapy is recommended)*?
   □ No □ Yes

4. Is the member on another DPP-4 inhibitor, or any agent within the GLP-1 agonist drug class?
   □ No □ Yes

5. Has the patient had an adequate trial (90 days) of ALL of the following medications for diabetes, unless allergy or intolerance*?
   a. Metformin
   b. Sulfonylurea
   c. Pioglitazone (if BMI <35)
   d. Jardiance
   e. Tradjenta
   f. Victoza[*PA]
   □ No □ Yes

[*PA]*This medication is also subject to PA review*

For continuation of therapy, please respond to <u>additional questions</u> below.

1. Is there documented A1C lowering of 0.5% from initial or A1C now at goal?
   □ No □ Yes

NOTES:
* Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment and do not require medication discontinuation

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**