GLP-1 (glucagon-like peptide-1) AGONISTS
STEP THERAPY REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
2. Is the patient currently being treated with the requested agent within the past 90 days? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? ☐ Yes ☐ No
3. Does the patient have or is at high risk for atherosclerotic cardiovascular disease, heart failure, and/or chronic kidney disease? ☐ Yes ☐ No
4. Has the patient tried and had an inadequate response to ONE or more of the following antidiabetic agents; an agent containing metformin or insulin? ☐ Yes ☐ No
   If yes, please specify agent(s): _____
5. Was ONE or more of the following antidiabetic agents; an agent containing metformin or insulin discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
   If yes, please specify agent(s): _____
6. Does the patient have an intolerance or hypersensitivity to ONE of the following antidiabetic agents; an agent containing metformin or insulin? ☐ Yes ☐ No
   If yes, please explain intolerance or hypersensitivity: _____
   _____
7. Does the patient have an FDA labeled contraindication to metformin AND insulin? ☐ Yes ☐ No
   If yes, please specify contraindication: _____
   _____
8. Is ONE or more of the following antidiabetic agents; an agent containing metformin or insulin expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No

Please continue to the next page.

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

9. Is ONE or more of the following antidiabetic agents; an agent containing metformin or insulin not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
10. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the one or more of the following antidiabetic agents; an agent containing metformin or insulin and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
    If yes, please specify agent(s): _____
11. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
12. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? ☐ Yes ☐ No
    If yes, please provide information to support therapy with a higher quantity (dose) for the requested indication: _____
    _____
    If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit? ☐ Yes ☐ No
    If no, please explain why the requested dose cannot be optimized: _____
    _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
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Eagan, MN 55121

TOLL FREE

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