INSULIN
PRIOR AUTHORIZATION 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 being treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? ☐ Yes ☐ No
2. Is the patient pregnant? ☐ Yes ☐ No
3. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
4. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify contraindications: _____
   _____
5. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____
   _____
   _____

For rapid insulin requests: (Please refer to the table below for preferred agents.)

Formulation	Preferred Agent(s)
Rapid Insulin	- **Fiasp** (insulin aspart) - **Fiasp Flextouch** (insulin aspart) - **Fiasp Penfill** (insulin aspart) - **Humalog** (insulin lispro) - **Humalog U200** (insulin lispro) - **Lyumjev** (insulin lispro-aabc) - **NovoLog** (insulin aspart)

Please continue to the next page.

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

6. Has the patient tried and had an inadequate response to ALL preferred rapid acting insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please specify agents tried: _____
   _____
   If no, were ALL preferred rapid acting insulin agents discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
   If yes, please specify agents: _____
   _____
   If no. are ALL preferred rapid acting insulin agents 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
   If no, are ALL preferred rapid acting insulin agents not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
   If no, is the patient currently using an insulin pump that has an incompatibility with ALL preferred rapid insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
   If no. does the patient have an intolerance or hypersensitivity to ALL preferred rapid acting insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please explain intolerance/hypersensitivity: _____
   _____
   If no. does the patient have an FDA labeled contraindication to ALL preferred rapid acting insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: _____
   _____
   If no. has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ALL preferred rapid acting insulin agents 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 agents tried: _____
   _____
   If no. does the patient have a physical or a mental disability that would prevent them from using ALL preferred insulin agents? ☐ Yes ☐ No
   If yes, please explain _____
   _____

For insulin requests: (Please refer to the table below for preferred agents.)

Formulation	Preferred Agent(s)
Mix Insulin	- **Humalog 75/25** (75% insulin lispro protamine suspension/25% insulin lispro) - **Humalog 50/50** (50% insulin lispro protamine suspension/50% insulin lispro) - **Humulin 70/30** (70% human insulin isophane suspension/30% human insulin) - **NovoLog 70/30** (70% insulin aspart protamine/30% insulin aspart)

7. Has the patient tried and had an inadequate response to ALL preferred mixed insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please specify agents tried: _____
   _____

Please continue to the next page.

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

If no, were ALL preferred mixed insulin agents discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

If yes, please specify agents: _____

_____

If no. are ALL preferred mixed insulin agents 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

If no, are ALL preferred mixed insulin agents not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No

If no, does the patient have an intolerance or hypersensitivity to ALL preferred mixed insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

If yes, please explain intolerance/hypersensitivity: _____

_____

If no. does the patient have an FDA labeled contraindication to ALL preferred mixed insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

If yes, please specify FDA labeled contraindication: _____

_____

If no. has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ALL preferred mixed insulin agents 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 agents tried: _____

_____

If no. does the patient have a physical or a mental disability that would prevent them from using ALL preferred insulin agents? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please fax or mail this form to:
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TOLL FREE

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