maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Insulin Pen

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the patient's indication or diagnosis?

[] Diabetes mellitus (If checked, go to 2)

[] Other (If checked, no further questions)

2 What is the requested medication?

[] Apidra (insulin glulisine) (If checked, go to 3)

[] Toujeo (insulin glargine 300 U/mL) (If checked, go to 7)

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

[] Tresiba (insulin degludec) (If checked, go to 8)

[] Basaglar (insulin glargine) (If checked, go to 8)

[] Semglee (insulin glargine-yfgn) (If checked, go to 8)

[] Humalog (insulin lispro) (If checked, go to 3)

[] Humulin (insulin regular) (If checked, go to 3)

[] Novolin (insulin NPH) (If checked, go to 8)

[] Novolog (insulin aspart) (If checked, go to 3)

[] Lantus (insulin glargine) (If checked, go to 8)

[] Fiasp (insulin aspart) (If checked, go to 3)

[] Lyumjev (insulin lispro-aabc) (If checked, go to 3)

3	Is the patient GREATER THAN 4 years of age? [If no, no further questions.]	Yes	No
4	Has the patient tried and failed the following formulary rapid-acting insulin product: Admelog? [If no, no further questions.]	Yes	No
5	Is the request for a generic formulation? [NOTE: If there is no generic formulation available for the requested insulin product, select 'Yes'.] [If yes, skip to question 11.]	Yes	No
6	Has the patient tried and failed the generic formulation? [If yes, skip to question 11.] [If no, no further questions.]	Yes	No
7	Does the patient require a dose GREATER THAN 100 units per day of BASAL insulin (such as Insulin glargine-yfgn)? [If no, no further questions.]	Yes	No
8	Has the patient tried and failed the following formulary long-acting insulin products: A) Insulin glargine-yfgn, B) Rezvoglar? [If no, no further questions.]	Yes	No
9	Is the request for a generic formulation? [NOTE: If there is no generic formulation available for the requested insulin product, select 'Yes'.] [If yes, skip to question 11.]	Yes	No

PRIOR AUTHORIZATION REQUEST

10	Has the patient tried and failed the generic formulation? [If no, no further questions.]	Yes	No
11	Is the patient greater than or equal to 18 years of age? [If yes, skip to question 13.]	Yes	No
12	Does the patient require multiple daily injections of insulin? [No further questions.]	Yes	No
13	Is the patient homeless? [If yes, no further questions.]	Yes	No
14	Does the patient have a caregiver who can administer insulin using vials and syringes? [If yes, no further questions.]	Yes	No
15	Is the patient unable to effectively use insulin vials and syringes to self-administer insulin due to uncorrectable visual disturbances (for example, macular degeneration, retinopathy, vision uncorrectable by prescription glasses)? [If yes, no further questions.]	Yes	No
16	Is the patient unable to effectively use insulin vials and syringes to self-administer insulin due to physical disability or dexterity problems due to stroke, peripheral neuropathy, trauma, or other physical condition?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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