HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

BASAL INSULIN

Insulin Glargine, Toujeo®, Insulin Degludec

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:							
DOB:	Gender:	Physician:							
Office Phone:	Office Fax:	Office Contact:							
Height/Weight:									
Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with									

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred

- 1. Preferred
 - A. Rezvoglar[™] (insulin glargine-aglr); no prior authorization required
- 2. Non-Preferred Brands with a single step; after trial and failure of Rezvoglar® and in accordance with Prior Authorization Criteria below
 - A. Insulin Degludec (100 Units/mL and 200 Units/mL)
- 3. Non-preferred Brands with a double step; after trial and failure of Rezvoglar® AND Insulin Degludec and in accordance with Prior Authorization Criteria below
 - A. Basaglar® (Insulin glargine 100 Units/mL), Toujeo® (Insulin glargine 300 Units/mL), Insulin glargine 100 Units/ml

Pro	duct being requested:								
Dosing/Frequency:									
If the request is for reauthorization, proceed to reauthorization section									
Questions		Yes	No	Comments/Notes					
Insulin Degludec									
1.	Does the member have a diagnosis of Type 1 or Type 2			Please provide documentation					
	diabetes mellitus or gestational diabetes?								
2.	Has the member trialed Basaglar® or Rezvoglar® for at least 3			Please provide documentation					
	months?								
Toujeo and Insulin Glargine									
1.	Does the member have a diagnosis of Type 1 or Type 2			Please provide documentation					
	diabetes mellitus or gestational diabetes?								
l		1	1	1					

2.	2. Has the member trialed Basaglar® or Rezvoglar® and Insulin			Please provide documentation			
	Degludec for at least 3 months?						
REAUTHORIZATION							
1.	Is the request for reauthorization of therapy?						
2.	Has the member's therapy been re-evaluated within the past 12 months?						
3.	Does the member show a continued medical need for the therapy?			Please provide documentation			
4.	Has the therapy been tolerable and effective?			Please provide documentation			
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.							
	ditional information:						
Pny	ysician Signature:						

Policy: PHARM-HU-011 Origination Date: 01/01/2022 Reviewed/Revised Date: 09/13/2023 Next Review Date: 09/13/2024 Current Effective Date: 01/01/2024

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.

^{*} Failure to submit clinical documentation to support this request will result in a dismissal of the request.**