HEALTHY U CHIP

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 CHIP 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 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

Product 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 diabetes mellitus or gestational diabetes?	☐	☐	**Please provide documentation**
2. Has the member trialed Basaglar® or Rezvoglar® for at least 3 months?	☐	☐	**Please provide documentation**
Toujeo and Insulin Glargine			
1. Does the member have a diagnosis of Type 1 or Type 2 diabetes mellitus or gestational diabetes?	☐	☐	**Please provide documentation**

2. Has the member trialed Basaglar® or Rezvoglar® and Insulin Degludec for at least 3 months?	☐	☐	**Please provide documentation**
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.			
Additional information:			
Physician Signature:			

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

Policy: PHARM-CHIP-011
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024