

## PRIOR AUTHORIZATION REQUEST FORM

### Insulins

Admelog, Afrezza, Apidra, Basaglar, Humalog U-200, Humulin-N, Humulin-R, insulin degludec, insulin glargine, insulin lispro protamine/lispro, Kirsty, Lyumjev, Merilog, Myxredlin, Novolin-N, Novolin-R, Novolin 70/30, Novolog, Rezvoglar, Soliqua, Tresiba, Xultophy

**For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

#### Short- Acting Insulin:

Preferred Products: Fiasp, Humalog U-100, insulin aspart, insulin lispro

Non-preferred Products: Admelog, Afrezza, Apidra, Humalog U-200, Humulin-R, Kirsty, Lyumjev, Merilog, Myxredlin, Novolin-R, Novolog

#### Intermediate Acting Insulin:

Preferred: Novolin-N

Non-preferred: Humulin-N

#### Long- Acting Insulin:

Preferred: Lantus, Semglee, Toujeo

Non-preferred: Basaglar, insulin degludec, insulin glargine, Rezvoglar, Soliqua\*, Tresiba, Xultophy\*

\* Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required

#### Insulin Mixtures:

Preferred: Humalog Mix 75/25, Humalog Mix 50/50, Humulin 70/30, insulin aspart protamine/aspart, Novolog 70/30

Non-preferred: Novolin 70/30, insulin lispro protamine/lispro

Product Requested: \_\_\_\_\_

Directions for Use: \_\_\_\_\_

| Non-Preferred Criteria for Approval at <i>least ONE</i> of the following criteria (1-9) must be met:   | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. <b>Trial/Failure of Preferred.</b> Has the patient tried and failed at least one preferred agent within the same PDL class at an appropriate dose and duration? | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug/Dose: _____ Reason for Failure: _____   |                          |                          |
| Treatment Dates: _____   |                          |                          |

|   |                          |                          |
|---|--------------------------|--------------------------|
| <p>2. <b>Cannot utilize Preferred.</b> Has the provider submitted appropriate clinical rationale for prescribing the non-preferred product over a preferred option within the same PDL class?</p> <p>Rationale: _____</p>   | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>3. <b>Continuation (from previous coverage).</b> Has the patient been treated with the requested non-preferred drug at a consistent dosage for at least 60 days in the most recent 90 days with clinical rationale to support why preferred products cannot be used? (<i>chart notes required</i>)</p> <p>Dates of Therapy: _____</p> <p>Details of Therapy: _____</p>   | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>4. <b>Brand required (when generic is mandated).</b> Has the provider submitted appropriate clinical rationale for dispensing the brand name medication instead of the generic?</p> <p>Rationale: _____</p>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>5. <b>Combination product (when single-entity products available).</b> Has the patient tried and failed individual agents in the combination product OR tried and failed a preferred agent in each of the combination product's therapeutic drug classes?</p> <p>Drug/Dose: _____ Reason for Failure: _____</p> <p>Drug/Dose: _____ Reason for Failure: _____</p> <p>Rationale: _____</p>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Limit Exceptions - Dose, Age, Quantity, and Indication (Off-label) Limit Exception Criteria for Approval</b>   |                          |                          |
| <p>6. <b>Quantity/Dose Limits.</b> Has the patient failed to achieve an adequate response within Medicaid's quantity/dose limit?</p> <p>Drug/Dose: _____ Reason for Failure: _____</p>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>7. <b>Age Limit.</b> Has the provider submitted appropriate clinical rationale for prescribing medication outside Medicaid's age limit?</p> <p>Rationale: _____</p>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>8. <b>Off-Label Indication.</b> Has the provider submitted supporting documentation required for any off-label indications, which includes at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years? Supporting documentation must be included. Compendia use must be recommended by generally accepted compendia such as American hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System.</p> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>9. <b>Other</b></p> <p>Details: _____</p>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Reauthorization</b>  |                          |                          |
| <p>1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response?</p>   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>PRESCRIBER CERTIFICATION</b>   |                          |                          |
| <p>I hereby certify this treatment is indicated, necessary and meets the guidelines for use.</p>  |                          |                          |
| <p>Physician's Signature: _____</p>   | <p>Date: _____</p>       |                          |

**Initial Authorization:** Up to six (6) months

**Reauthorization:** Up to one (1) year

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

Policy: PHARM-HYB-178  
Origination Date: 01/01/2026  
Reviewed/Revised Date:  
Next Review Date:  
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