



## GLP-1 Agonists Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

<b>Member Information</b> <small>(required)</small>			<b>Provider Information</b> <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

<b>Medication Information</b> <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

<b>Clinical Information</b> <small>(required)</small>	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Type 2 diabetes mellitus	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Quantity limit requests:</b>	
What is the quantity requested per MONTH? _____	
<b>What is the reason for exceeding the plan limitations?</b>	
<input type="checkbox"/> Titration or loading dose purposes	
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)	
<input type="checkbox"/> Requested strength/dose is not commercially available	
<input type="checkbox"/> Other: _____	

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-855-401-4262.  
This form may be used for non-urgent requests and faxed to 1-844-403-1029.