Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Insulins Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Insulins.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

Medications:

- ADMELOG SOLN 100 UNIT/ML
- ADMELOG SOLOSTAR SOPN 100 UNIT/ML
- APIDRA SOLN 100 UNIT/ML
- APIDRA SOLOSTAR SOPN 100 UNIT/ML
- FIASP FLEXTOUCH SOPN 100 UNIT/ML
- FIASP PENFILL SOCT 100 UNIT/ML
- FIASP SOLN 100 UNIT/ML
- HUMALOG KWIKPEN SOPN 100 UNIT/ML
- HUMALOG KWIKPEN SOPN 200 UNIT/ML
- HUMALOG SOCT 100 UNIT/ML
- HUMALOG SOLN 100 UNIT/ML
- HUMALOG MIX 50/50 KWIKPEN SUPN (50-50) 100 UNIT/ML
- HUMALOG MIX 50/50 SUSP (50-50) 100 UNIT/ML
- HUMALOG MIX 75/25 KWIKPEN SUPN (75-25) 100 UNIT/ML
- HUMALOG MIX 75/25 SUSP (75-25) 100 UNIT/ML
- INSULIN ASPART FLEXPEN SOPN 100 UNIT/ML
- INSULIN ASPART PENFILL SOCT 100 UNIT/ML
- INSULIN ASPART SOLN 100 UNIT/ML
- INSULIN ASPART PROT & ASPART SUSP (70-30) 100 UNIT/ML
- INSULIN ASP PROT & ASP FLEXPEN SUPN (70-30) 100 UNIT/ML
- INSULIN LISPRO (1 UNIT DIAL) SOPN 100 UNIT/ML
- INSULIN LISPRO PROT & LISPRO SUPN (75-25) 100 UNIT/ML
- INSULIN LISPRO SOLN 100 UNIT/ML
- NOVOLIN 70/30 FLEXPEN RELION SUPN (70-30) 100 UNIT/ML
- NOVOLIN 70/30 RELION SUSP (70-30) 100 UNIT/ML
- NOVOLIN R FLEXPEN RELION SOPN 100 UNIT/ML
- NOVOLIN R RELION SOLN 100 UNIT/ML
- NOVOLOG FLEXPEN SOPN 100 UNIT/ML
- NOVOLOG PENFILL SOCT 100 UNIT/ML
- NOVOLOG SOLN 100 UNIT/ML
- NOVOLOG MIX 70/30 FLEXPEN SUPN (70-30) 100 UNIT/ML
- NOVOLOG MIX 70/30 SUSP (70-30) 100 UNIT/ML

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Prescriber Information

Prescriber Name: ______________________________ Specialty: ____________________________ NPI: _________________

Prescriber Address: ____

Prescriber Phone #: __________________________ Prescriber Fax #: ___________________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _________________________

2. Indicate the patient's diagnosis for the requested medication: ______________________________________

3. Did the member have a failed adequate trial or documented intolerance with preferred insulin isophane/insulin regular (Humulin 70/30; Humulin N; Humulin R)?
   □ No □ Yes

4. Pens reserved for the following situations:
   a. Is the member unable to self-inject insulin due to cognitive function, difficulties with manual dexterity, visual disturbances, visual impairment, uncorrectable poor injection, **OR**
   b. Pediatric patients who are required to use such a device by their school, **OR**
   c. Patients requiring small doses of insulin (<5 units per dose)

   □ No □ Yes

5. Has the member failed adequate trial or documented intolerance with Humalog?

   □ No □ Yes

Humalog VIAL reserved for the following patients:

6. Does the member have Type 1 Diabetes, **OR**
   □ No □ Yes

7. On insulin pump therapy, **OR**
   □ No □ Yes

8. Is the member pregnant **OR**
   □ No □ Yes

9. Does the member have Type 2 Diabetes and require intensive glycemic control (≥4 injections per day) **AND** not controlled or recurrent hypoglycemia (low blood sugar) with regular insulin defined as ≥3 episodes of low blood sugar (<70 mg/dL) over the preceding 30 days that persists despite regular insulin dose adjustments, **OR**
   □ No □ Yes

10. Has failed adequate trial or documented intolerance with preferred insulin products (Humulin 70/30; Humulin N; Humulin R)?
    □ No □ Yes

Humalog PENS reserved for the following patients:

11. Is the member unable to draw up insulin accurately from a vial with a syringe due to young age, visual impairment, physical disabilities (i.e., amputation, tremors/Parkinson's disease, rheumatoid arthritis)? **OR**
    □ No □ Yes
12. Requires small doses of insulin (<5 units per dose), **OR**
    □ No □ Yes
13. Is the member pediatric and is required to use such a device by their school?
    □ No □ Yes

For continuation of therapy, please respond to additional questions below.

1. Adherence (>80%) to diabetic regimen, **AND**
   □ No □ Yes
2. Must continue to meet inclusion criteria
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	Date:

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