



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Levemir, Tresiba & Toujeo**. 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: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

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: _____

Clinical Criteria:

1. Member has an intolerance or failed an adequate trial of NPH AND insulin glargine-yfgn (unbranded Semglee),
 No Yes
2. **AND** prescribed for Type 1 Diabetes as basal insulin,
 No Yes
3. **OR** prescribed for member with Type 2 Diabetes who experiences recurrent nocturnal hypoglycemia (low blood sugar at night) with bedtime NPH insulin dosing defined as: ≥ 3 episodes of nocturnal capillary blood glucose (CBG) at night < 70 mg/dL over the preceding 30 days,
 No Yes
4. **OR** prescribed for member with Type 2 Diabetes on NPH insulin that experiences any episode of severe hypoglycemia defined as: hypoglycemia resulting in seizures, loss of consciousness, episode necessitating assistance from someone else, and/or use of glucagon,
 No Yes
5. **OR** prescribed for member with Type 2 Diabetes that requires ultra-long-acting insulin due to work (i.e., night shift work where hours of sleep are significantly and repeatedly varied over time, frequent time-zone traveler)
 No Yes

SoloStar/Pen Criteria (must meet above criteria) PLUS:

1. 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),
 No Yes
2. **OR** requires small doses of insulin (< 5 units per dose),
 No Yes
3. **OR** pediatric member who 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,
 No Yes
2. **AND** member has documented A1C lowering of 0.5% from initial or A1C now at goal
 No Yes
3. **AND** must continue to meet inclusion criteria
 No Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:

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

Prescriber Signature:	Date:
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