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: Pharmacy | Community Provider Portal | Kaiser Permanente

Medications:

• ADMELOG SOLN 100 UNIT/ML	• INSULIN ASPART PROT & ASPART SUSP (70-30) 100 UNIT/ML
• ADMELOG SOLOSTAR SOPN 100 UNIT/ML	• INSULIN ASP PROT & ASP FLEXPEN SUPN (70-30) 100 UNIT/ML
• APIDRA SOLN 100 UNIT/ML	• NOVOLIN 70/30 FLEXPEN RELION SUPN (70-30) 100 UNIT/ML
• APIDRA SOLOSTAR SOPN 100 UNIT/ML	• NOVOLIN 70/30 RELION SUSP (70-30) 100 UNIT/ML
• FIASP FLEXTOUCH SOPN 100 UNIT/ML	• NOVOLIN R FLEXPEN RELION SOPN 100 UNIT/ML
• FIASP PENFILL SOCT 100 UNIT/ML	• NOVOLIN R RELION SOLN 100 UNIT/ML
• FIASP SOLN 100 UNIT/ML	• NOVOLOG FLEXPEN SOPN 100 UNIT/ML
• HUMALOG KWIKPEN SOPN 200 UNIT/ML*	• NOVOLOG PENFILL SOCT 100 UNIT/ML
• INSULIN ASPART FLEXPEN SOPN 100 UNIT/ML	• NOVOLOG SOLN 100 UNIT/ML
• INSULIN ASPART PENFILL SOCT 100 UNIT/ML	• NOVOLOG MIX 70/30 FLEXPEN SUPN (70-30) 100 UNIT/ML
• INSULIN ASPART SOLN 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 start date: _____

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

Clinical Criteria (All products <u>except</u> starred Humalog formulations above):

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

2. If ordering a rapid or short-acting insulin, has the patient failed adequate trial or has documented intolerance to Humalog?
   □ No □ Yes □ N/A – not ordering a rapid or short-acting insulin

3. If ordering a pen formulation, does patient meet at least ONE of the following criteria for use of insulin pens?
   - Patient is unable to self-inject insulin due to cognitive function, difficulties with manual dexterity, visual disturbances, visual impairment, uncorrectable poor injection
   - Pediatric patient who is required to use such a device by their school
   - Patient requiring small doses of insulin (<5 units per dose)

   □ No □ Yes □ N/A – not ordering a pen

Clinical Criteria (All starred Humalog formulations above):

1. One of the following situations applies:
   a. Type 1 Diabetes
      □ No □ Yes

   b. **OR** on insulin pump therapy
      □ No □ Yes

   c. **OR** pregnant
      □ No □ Yes

   d. **OR** member has Type 2 Diabetes and requires 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
      □ No □ Yes

   e. **OR** failed adequate trial or documented intolerance with preferred insulin products (Humulin 70/30; Humulin N; Humulin R)
      □ No □ Yes

2. **AND** if ordering Humalog PENS/CARTRIDGES, one of the following situations applies:
   a. Member is 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

   b. **OR** requires small doses of insulin (<5 units per dose)
      □ No □ Yes

   c. **OR** pediatric patient who is required to use such a device by their school
      □ No □ Yes

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

1. Is the patient at least 80% adherent to diabetic regimen?
   □ No □ Yes

2. Does the patient 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:**

_____

_____

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

Prescriber Signature:	**Date:**