**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Antihyperglycemics, Insulin, Long Acting – GLP-1 Receptor Agonists (Xultophy & Soliqua)**
**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 **Antihyperglycemics, Insulin, Long Acting – GLP-1 Receptor Agonists (Xultophy & Soliqua)** for **Commercial** and **FEHB (Federal)** plans**.** 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 intolerance or failed an adequate trial of NPH AND insulin glargine-yfgn (unbranded Semglee),
   □ No □ Yes

2. **AND** diagnosis of Type 2 Diabetes with:
   a. Recurrent nocturnal hypoglycemia 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 despite NPH insulin dose reduction,
   b. **OR** 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,
   c. **OR** 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

3. **AND** had a recent A1C <9%,
   □ No □ Yes

4. **AND** diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD),
   □ No □ Yes

5. **AND** had a failure or contraindication to SGLT2-inhibitor AND preferred GLP-1 (Victoza, Ozempic)
   □ No □ Yes

**For continuation of therapy, please respond to <u>additional questions</u> below.**

1. Adherence (>80%) to diabetic regimen,
   □ No □ Yes

2. **AND** 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:** |
|---|---|
| | |