



**Kaiser Permanente Health Plan of Mid Atlantic States, Inc.
Dipeptidyl Peptidase-IV (DPP-IV) Inhibitors Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year**

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Dipeptidyl Peptidase-IV (DPP-IV) Inhibitors**. Please complete and 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 this form is complete. The KP-MAS Formulary can be found at: <http://pithelp.appl.kp.org/MAS/formulary.html>**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Please check the boxes that apply:

Initial Request Continuation of Therapy Request

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

Diagnosis of Type 2 Diabetes:

No Yes

6 – Clinical Criteria

Patients with A1c% < 7.5%:

- Documented Trial of ≥ 90 days with metformin (unless contraindicated)

Dates of metformin therapy: _____

Patients with A1c% $\geq 7.5\%$:

- Initiated therapy both metformin (unless contraindicated), plus a second agent (Sulfonylurea, DPP-IV, SGLT-2, GLP-1, TZD) [90-day trial is not required]

If contraindicated to metformin, please select from the following:

- eGFR below 45 mL/min/1.73m² for initiation of therapy
- eGFR below 30 mL/min/1.73m² for maintenance therapy
- Known hypersensitivity
- Acute or chronic metabolic acidosis including diabetic ketoacidosis

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

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

Provider Signature:

Date:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility