



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:

| | |
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| <ul style="list-style-type: none"> • 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 200 UNIT/ML* • INSULIN ASPART FLEXPEN SOPN 100 UNIT/ML • INSULIN ASPART PENFILL SOCT 100 UNIT/ML • INSULIN ASPART SOLN 100 UNIT/ML | <ul style="list-style-type: none"> • INSULIN ASPART PROT & ASPART SUSP (70-30) 100 UNIT/ML • INSULIN ASP PROT & ASP FLEXPEN SUPN (70-30) 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 start date: _____
2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria (All products except 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:

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