Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
DPP4 Inhibitors 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 **DPP4 Inhibitors.** 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:

• NESINA • ONGLYZA • JANUVIA • KAZANO • KOMBIGLYZE XR	• JANUMET • JANUMET XR • OSENI

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:

1. Diagnosis of diabetes mellitus type 2,
   □ No □ Yes

2. **AND** patient >18 years old,
   □ No □ Yes

3. **AND** HbA1c within 90 days of the PA request:
   □ No □ Yes: Result________ Date__________

4. **AND** absence of intolerance, contraindications, or hypersensitivity reactions to DPP4 inhibitors,
   □ No □ Yes

5. **AND** adequate trial (90 days) of KP preferred oral medications: metformin, sulfonylurea, and pioglitazone at maximum tolerated dose unless resulting in a therapeutic failure, contraindication, or intolerance
   □ No □ Yes

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

1. Documentation of continued medical necessity including HbA1c result within 90 days
   □ No □ Yes: Result________Date__________

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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