Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Hypoglycemics, Insulin and Related Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, Insulin and Related Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Hypoglycemic, Insulin and Related Agent. See the Preferred Drug List (PDL) for the list of preferred Hypoglycemics, Insulin and Related Agents at: https://papdl.com/preferred-drug-list.
2. A glucagon-like peptide-1 (GLP-1) receptor agonist when there is a record of a recent paid claim for another GLP-1 receptor agonist or a dipeptidyl peptidase 4 (DPP-4) inhibitor (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Hypoglycemic, Insulin and Related Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Hypoglycemic, Insulin and Related Agent that does not contain a glucagon-like peptide-1 (GLP-1) receptor agonist, **both** of the following:
   a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Insulin and Related Agents with the same duration of action
   b. Has a history of contraindication or intolerance to the preferred Hypoglycemics, Insulin and Related Agents that would not be expected to occur with the requested medication;

   AND
2. For a non-preferred Hypoglycemic, Insulin and Related Agent that contains a GLP-1 receptor agonist, **both** of the following:
   a. Has a clinical reason why a preferred basal insulin and a preferred GLP-1 receptor agonist cannot be used
   b. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Insulin and Related Agents that contain a GLP-1 receptor agonist;

   AND
3. For Afrezza (insulin human inhalation powder), **all** of the following:
   a. Is prescribed Afrezza (insulin human inhalation powder) for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,
   b. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   c. Is prescribed Afrezza (insulin human inhalation powder) by or in consultation with an endocrinologist,
   d. Does not have a contraindication to the prescribed medication;

AND

4. For therapeutic duplication of a GLP-1 receptor agonist, **one** of the following:
   a. Is being transitioned to or from another GLP-1 receptor agonist or DPP-4 inhibitor with the intent of discontinuing one of the medications
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR AFREZZA (insulin human inhalation powder): The determination of medical necessity of a request for renewal of a prior authorization for Afrezza (insulin human inhalation powder) that was previously approved will take into account whether the beneficiary:

1. Has documentation of a positive clinical response to the medication as documented by a decrease in hemoglobin A1c; **AND**

2. Is prescribed Afrezza (insulin human inhalation powder) by or in consultation with an endocrinologist; **AND**

3. Does not have a contraindication to the prescribed medication.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Hypoglycemic, Insulin and Related Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM *(form effective 01/01/20)*

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

Please refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:	Dosage form:	Strength:
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Has the beneficiary taken the requested non-preferred medication in the past 90 days? *(submit documentation)*..... ☐Yes ☐No

Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. *Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.*

☐Treatment failure or inadequate response with preferred medication(s) *(include drug name, dose, and start/stop dates)*:

_____

_____

☐Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Contraindication to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Unique clinical or age-specific indications supported by FDA approval or medical literature *(describe)*:

_____

_____

☐Absence of preferred medication(s) with appropriate formulation *(list medical reason formulation is required)*:

_____

_____

☐Drug-drug interaction with preferred medication(s) *(describe)*:

_____

_____

☐Other medical reason(s) the beneficiary cannot use the preferred medication(s) *(describe)*:

_____

_____

☐For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date: