

## **I. Requirements for Prior Authorization of Hypoglycemics, DPP-4 Inhibitors**

### **A. Prescriptions That Require Prior Authorization**

All prescriptions for Hypoglycemics, DPP-4 Inhibitors must be prior authorized.

### **B. Review of Documentation for Medical Necessity**

In evaluating a request for prior authorization of a prescription for a Hypoglycemics, DPP-4 Inhibitor, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Has a history of therapeutic failure of or a contraindication or an intolerance to metformin; **AND**
2. For a non-preferred Hypoglycemics, DPP-4 Inhibitor, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics, DPP-4 Inhibitors approved or medically accepted for the beneficiary's diagnosis. See the Preferred Drug List for the list of preferred Hypoglycemics, DPP-4 Inhibitors at: <https://papdl.com/preferred-drug-list>; **AND**
3. For therapeutic duplication of a DPP-4 inhibitor when there is a record of a recent paid claim for another DPP-4 inhibitor or a glucagon-like peptide-1 (GLP-1) receptor agonist in the point-of-sale online claims adjudication system, **one** of the following:
  - a. Is being transitioned to or from another DPP-4 inhibitor or a GLP-1 receptor agonist with the intent of discontinuing one of the drugs
  - b. Has a medical reason for concomitant use of the requested drugs 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.

### **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 Hypoglycemics, DPP-4 Inhibitor. If the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the applicable 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.

**HYPOGLYCEMICS, DPP-4 INHIBITORS PRIOR AUTHORIZATION FORM** (form effective 1/1/2026)

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:		
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		City/state/zip:		
Beneficiary ID#:	DOB:	Phone:	Fax:	

**CLINICAL INFORMATION**

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx code ( <i>required</i> ):	
<b>For ALL Hypoglycemics, DPP-4 Inhibitors:</b> Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to metformin?		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
<b>For a NON-PREFERRED Hypoglycemics, DPP-4 Inhibitor:</b> Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, DPP-4 Inhibitors approved or medically accepted for the beneficiary's diagnosis?  <i>(Refer to <a href="https://papd.com/preferred-drug-list">https://papd.com/preferred-drug-list</a> for a list of preferred and non-preferred drugs in this class.)</i>		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION**

Prescriber Signature:	Date:
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