Adlyxin (lixisenatide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Type II diabetes ☐ Other diagnosis: _____ ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Lab Values:
Was the patient's most recent HbA1c in the past 6 months or prior to starting the requested medication 7.0% or greater? ☐ Yes ☐ No
Documentation of HbA1c level required.

Is the patient's estimated glomerular filtration rate (GFR) less than or equal to 45 mL/min/1.73 m2? ☐ Yes ☐ No
Documentation of GFR required.

Does the patient currently have a serum creatinine level exceeding 1.8 mg/dL or an estimated GFR less than 30 mL/min/1.73 m2? ☐ Yes ☐ No
Documentation required.

Clinical information:
Has the patient tried or is the patient currently taking metformin? ☐ Yes ☐ No

Has treatment with metformin been avoided due to lactic acidosis or elevated liver enzymes? ☐ Yes ☐ No

Does the patient have advanced liver disease with at least one of the following? ☐ Yes ☐No
If yes, please select:
☐ Ascites
☐ Cirrhosis
☐ Hepatic encephalopathy
☐ Portal hypertension

Is the patient currently taking any of the following medications? ☐ Yes ☐ No
If yes, please select:
☐ Janumet/Janumet XR (sitagliptin/metformin)
☐ Januvia (sitagliptin)
☐ Jentadueto/Jentadueto XR (linagliptin/metformin)
☐ Kazano (alogliptin/metformin) ☐ Kombiglyze XR (saxagliptin/metformin)
☐ Nesina (alogliptin)
☐ Onglyza (saxagliptin)

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□ **Oseni (alogliptin/pioglitazone)**
□ **Tradjenta (linagliptin)**
□ **Glyxambi (empagliflozin/linagliptin)**
□ **Seglujan (ertugliflozin/sitagliptin)**
□ **Qtern (dapagloflozin/saxagliptin)**

If the patient is taking any of the above medications, will concomitant therapy with those medications be discontinued? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811