PRIOR AUTHORIZATION REQUEST

INSULIN PRODUCTS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

Version 06.2026

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No

7 What is the patient's indication or diagnosis?

[] Diabetes mellitus (If checked, go to 8)

[] Other (If checked, no further questions)

8 What is the requested medication?

[] Apidra (insulin glulisine) (If checked, go to 9)

[] Novolog (insulin aspart) (If checked, go to 10)

[] Fiasp (insulin aspart) (If checked, go to 10)

[] Kirsty (insulin aspart-xjhz) (If checked, go to 10)

[] Merilog (insulin aspart-szjj) (If checked, go to 10)

[] Humalog (insulin lispro) (If checked, go to 10)

[] Lyumjev (insulin lispro-aabc) (If checked, go to 10)

[] Humulin (insulin regular) (If checked, go to 10)

[] Humulin U-500 (insulin regular) (If checked, go to 11)

[] Toujeo (insulin glargine 300 U/mL) (If checked, go to 11)

[] Tresiba (insulin degludec) (If checked, go to 12)

PRIOR AUTHORIZATION REQUEST

	[] Lantus (insulin glargine) (If checked, go to 12)		
	[] Awiqli (insulin icodec-abae) (If checked, go to 12)		
	[] Basaglar (insulin glargine) (If checked, go to 12)		
	[] Semglee (insulin glargine-yfgn) (If checked, go to 12)		
	[] Levemir (insulin detemir) (If checked, go to 12)		
	[] Novolin (insulin NPH) (If checked, go to 12)		
9	Is the patient GREATER THAN 4 years of age? [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm that the patient has tried and failed the following formulary rapid-acting insulin product: Admelog? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the patient require a dose GREATER THAN 100 units per day of BASAL insulin (such as Insulin glargine-yfgn)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has tried and failed ALL of the following formulary long-acting insulin products: A) Insulin glargine-yfgn, B) Rezvoglar? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Is the request for a generic formulation? [Note: If there is no generic formulation available for the requested insulin product, select 'Yes'.] [If yes, skip to question 15.]	Yes	No
14	Has the patient tried and failed the generic formulation? [If no, no further questions.]	Yes	No
15	Does the requested dose exceed FDA approved label dosing for the requested indication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250

Version 06.2026