DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Prior Authorization Request Form

GIP/GLP-1 & GLP-1 Agonists (Type 2 Diabetes)

☐Standard ☐Urgent ☐Reconsideration/Appeal

Patient Information

Patient Name: _____ DOB (mm/dd/yyyy): _____ Gender: _____

Address: _____ City: _____ State & Zip: _____

Cardholder ID: _____ Group #: _____ Relationship Code: _____

Phone Number: _____ Email address: _____

Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State & Zip: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Medication Information

Drug Name: _____ Strength: _____ Quantity: _____

Directions: _____ Day Supply: _____

Indicate Request Type: ☐New Start ☐Renewal Therapy Start Date (if applicable): _____

Diagnosis: _____ ICD 10 Code: _____

Prior Authorization Request Information

Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays

For all requests:

1. Does the patient have any FDA contraindications to the requested agent? ☐Yes ☐No
2. Will the patient be taking any other medications in combination with the requested agent for the treatment of this diagnosis? If yes, please list: _____ ☐Yes ☐No
3. What is the patient's baseline A1c? Must submit lab results. _____ Date: _____
4. Will the requested agent be used in combination with lifestyle (diet & exercise) intervention? ☐Yes ☐No
5. Will the requested agent be used in combination with a dipeptidyl peptidase-4 inhibitor (DPP-4 inhibitor) (i.e., alogliptin, linagliptin, saxagliptin, sitagliptin)? ☐Yes ☐No
6. Will the requested agent be used in combination with another GLP-1 or GLP-1/GIP agonist (i.e. tirzepatide, semaglutide, dulaglutide, liraglutide, etc.)? ☐Yes ☐No
7. Has the patient had an inadequate clinical response, intolerance, or contraindication to at least a 90-day supply of maximally tolerated metformin? If yes, please list below & provide documentation. ☐Yes ☐No

Drug Name/Strength:	Start Date:	End Date:	Outcome:

Please continue to the next page.

Patient Name:	DOB:

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Renewal Requests:

8. **Has the patient had a positive clinical response to therapy as evidenced by a reduction in A1c? Must submit objective documentation.** ☐**Yes** ☐**No**
   What is the patient's baseline A1c? Must submit lab results. _____Date: _____
   What is the patient's current A1c? Must submit lab results. _____ Date: _____
9. **Does the patient have any FDA contraindications to the requested agent?** ☐**Yes** ☐**No**
10. **Will the requested agent be used in combination with a dipeptidyl peptidase-4 inhibitor (DPP-4 inhibitor) (i.e., alogliptin, linagliptin, saxagliptin, sitagliptin)?** ☐**Yes** ☐**No**
11. **Will the requested agent be used in combination with another GLP-1 or GLP-1/GIP agonist (i.e. tirzepatide, semaglutide, dulaglutide, liraglutide, etc.)?** ☐**Yes** ☐**No**

Prescriber Signature: _____ **Date**: _____

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

Additional Comments/Notes: