DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Trexlertown, PA 18087-0035
Phone: 480-561-6005
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Prior Authorization Request Form

Insulin – Long & Short acting

☐ Standard ☐ Urgent

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

Please be aware that our preferred insulins are insulin lispro, insulin aspart, insulin glargine, insulin glargine-yfgn, and insulin degludec. Any preferred brand name insulin will require an inadequate clinical response with one of the a preferred generic insulin of similar duration of action (for example: Humalog/Novolog require an inadequate clinical response with insulin aspart or insulin lispro).

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. Has the patient had an inadequate clinical response of at least 12 weeks, intolerance, or contraindication to any medications used to treat this diagnosis? If yes, please list below. ☐ Yes ☐ No

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

Please continue to the next page.

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Patient Name:	DOB:

For Renewal Requests:

1. **Has the patient had a positive clinical response to therapy? Must submit objective documentation.** ☐**Yes** ☐**No**
2. **Does the patient have any FDA contraindications to the requested agent?** ☐**Yes** ☐**No**

Prescriber Signature: _____ **Date**: _____

Authorized Agent's Name: _____

Please fax this request to 602-669-1169 or our secure email at PriorAuthorizations@disclosedrx.com

Additional Comments/Notes:

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