DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Phone: 480-561-6005
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# Prior Authorization Request Form

## Insulin – Long & Short acting

☐ 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***

*Please be aware that our preferred insulins are insulin lispro, insulin aspart, insulin glargine, insulin glargine-yfgn, and insulin degludec. Any brand name insulin will require an inadequate clinical response with one of the following generic products 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: |
|---|---|---|---|
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| | | | |
| | | | |

Please continue to the next page.

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

**Additional Comments/Notes:**