

HYPOGLYCEMICS, DPP-4 INHIBITORS PRIOR AUTHORIZATION FORM (form effective 1/1/2026)

Prior authorization guidelines for **Hypoglycemics, DPP-4 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		total # of pgs: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis (<u>submit documentation</u>):		DX code (<u>required</u>):	
For ALL Hypoglycemics, DPP-4 Inhibitors: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to metformin?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit documentation.
For a NON-PREFERRED Hypoglycemics, DPP-4 Inhibitor: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, DPP-4 Inhibitors approved or medically accepted for the beneficiary's diagnosis? (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit documentation.

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	Date:
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