Antidiabetics – GLP-1 Agonists

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington. Inc. Preferred Drug list: https://pharmacy.envolvehealth.com/content/dam/centene/envolve-pharmacy-solutions/pdfs/PDL/FORMULARY-CoordinatedCare_Washington.pdf

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation showing a positive clinical response? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Type 2 diabetes
   ☐ Type 2 diabetes with established atherosclerotic cardiovascular disease (ASCVD) or risk factors
   ☐ Other. Specify:

3. Provide patient's HbA1c for the following:
   Baseline: _____ Date taken: _____
   Current (within last 12 mos.): _____ Date taken: _____

4. List all medications patient has previously tried or has a history of failure, defined as inability to achieve glycemic control or, intolerance and include the duration of use and reason for discontinuation for each medication.

5. List any alternatives that the patient has contraindication to or are clinically inappropriate:

Chart notes and documentation of HbA1c measurements are required with this request

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)