HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
BASAL INSULIN
Basaglar®, Lantus®, Levemir®, Toujeo®, Tresiba®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred

1. Preferred
    A. Basaglar® (Insulin glargine 100 Units/mL)
2. Non-Preferred Brands with a single step; after trial and failure of Basaglar in accordance with Prior Authorization Criteria below
    A. Tresiba® (Insulin degludec 100 Units/mL and 200 Units/mL)
3. Non-preferred Brands with a double step; after trial and failure of Basaglar® AND Tresiba®
    A. Toujeo®(Insulin glargine 300 Units/mL), Lantus® (Insulin glargine 100 Units/ml), Levemir® (Insulin detemir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
BASALGAR®			
1. Is the request for Basaglar®? If so, no other questions.	☐	☐	
TRESIBA®			
1. Has the member trialed insulin glargine (Basaglar® or Lantus®) for at least 3 months?	☐	☐	**Please provide documentation**
2. Does the member meet at least one of the following criteria: • Requires more than 160 units of long acting insulin per day • Experiences more than 3 episodes of nocturnal hypoglycemia in a calendar year or has a history of hypoglycemia unawareness requiring the assistance of another individual or hypoglycemia-associated autonomic failure	☐	☐	**Please provide documentation**

• Lipodystrophy due to the volume of daily injections • Social or cognitive issues that make adherence to prescribed insulin more likely with Tresiba®			
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
4. Has the therapy been tolerable and effective?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

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Policy PHARM-011
Origination Date: 03/20/2018
Reviewed/Revised Date: 12/22/2020
Next Review Date: 12/22/2021
Current Effective Date: 01/01/2021