

Prior Authorization Request Form for
generic insulin lispro



7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Please note:

- **Brand Humalog or brand Admelog** are the preferred products over authorized generic insulin lispro and are covered **without prior authorization**.
- You do NOT need to complete this form for coverage of **brand name Humalog or brand name Admelog**. The purpose of this form is to provide information that will be used to determine if the use of the non-preferred authorized generic insulin lispro is medically necessary instead of brand name Humalog or brand name Admelog.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

Please provide a patient-specific justification as to why the brand Humalog or brand Admelog products cannot be used in this patient:

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____	_____
Prescriber Signature	Date

[2 October 2019]

For Internal Use Only

<input type="checkbox"/> Approved:	Duration of Approval: _____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: