

Prior Authorization Request Form for Insulin
glargine 300 U/mL (Toujeo)



7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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

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

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:

1. Is the patient 6 years old or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Coverage not approved
2. Does the patient have diabetes?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Coverage not approved
3. Is the patient using a minimum of 100 units of Lantus (insulin glargine) per day?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Coverage not approved
4. Does the patient require a dosage increase with Lantus?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Coverage not approved
5. Has the patient experienced a clinically significant severe hypoglycemia episode, despite splitting the Lantus dose?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Coverage not approved
6. Has the patient been counseled regarding the risk of dosing errors?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

Note: The following are not acceptable reasons for prior authorization of Toujeo:

- Non-adherence to previous insulin treatment
- Patient or prescriber preference for the use of Toujeo
- Patient or prescriber preference for a smaller injection volume

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

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Prescriber Signature

Date

[3 January 2020]

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: