Partnership HealthPlan Of California

PHC PHARMACY SERVICES
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Pharmacy TAR Supplemental Form: Antidiabetic agents

The information provided will be used to assist with clinical evaluation of prior authorization requests submitted when STEP therapy or prior authorization criteria has not been met.

IDENTIFYING INFORMATION	
Patient name:	Prescriber: Contact number:
Member ID:	TAR #:

RELEVANT MEDICAL INFORMATION			
Provide copy of recent A1C lab results (within last 90 days).			
Patient specific target A1C:	□ < 7.0%	□ 7.0 to 8.0%	Other:
Provide recent BMI:	□ BMI < 30	□ BMI 30 – 35	□ BMI > 35
Renal function:	□ eGFR < 30 ml/min	□ eGFR 30 - 59 ml/min	□ eGFR > 60 ml/min

MEDICATIONS TRIED: minimum trial of 3 consecutive months on two antihyperglycemic agents		
Drug:	Total daily dose and # of months on this dose:	Reason for inadequate response, intolerance, or contraindication to this medication:
Metformin		
Sulfonylureas: □ Glipizide □ Glimepiride □ Glyburide		
Long-acting insulin (required if A1C > 8.0%): □ Lantus □ Levemir		
Other:		

Please provide the most recent progress note and any additional justification if applicable. Progress notes documenting contraindication to, or intolerance to above medications need to be provided. If recommended by an endocrinologist, submit consult notes.