MOLINA HEALTHCARE
Non-Preferred Incretin Mimetics
Service Authorization (SA) Form

If the following information is not complete, correct, or legible, the SA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: – –

Gender ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: – –

Fax Number: – –

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

All drugs in this class are eligible to receive a twelve (12)-month approval. Complete the following questions.

1. Does the member have a diagnosis of type 2 diabetes mellitus?

☐ Yes ☐ No

If **Yes**, please provide the value of the lab that was performed within the last 12 months, and has been used to confirm the member's diagnosis along with the date of the result (A1c of greater than or equal to 6.5 is required for first starts):

☐ **A1c**. Value: _____ Date: _____

2. Has the member tried and failed an adequate trial of 2 different preferred products?

☐ Yes ☐ No

If **Yes**, please specify the drug, the length of the member's trial, and reason for discontinuation.

Drug 1: _____

Drug 2: _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be faxed to (844) 278-5731 or you may call (800) 424-4518 (TTY/TDD:711).