



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Admelog & Admelog<sup>®</sup> SoloStar<sup>®</sup> Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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Member Name:			Provider Name:			
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	Zip:	Office Street Address:			
Phone:			City:	State:		Zip:

Medication Information <small>(required)</small>
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Medication Name:		Strength:		Dosage Form:	
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:			
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					

Clinical Information <small>(required)</small>
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**\*\*\*Please note: A review of the vial will be conducted unless otherwise indicated.\*\*\***

**Select the diagnosis below:**

- Type 1 diabetes mellitus
- Type 2 diabetes mellitus

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**The following are the formulary alternatives:**

For Admelog SoloStar- **Humalog cartridge, Humalog Junior KwikPen, Humalog KwikPen**

For Admelog vial- **Humalog vial**

Will the patient be switched to one of the formulary alternatives?  **Yes**  **No**

If **yes**, please specify which alternative the patient will be switched to and notify the pharmacy of the change: \_\_\_\_\_

If the patient **CANNOT** be switched to a formulary alternative, please answer ALL of the following questions:

- 1) What previous medication(s) has the patient tried or failed for the diagnosis provided:  
\_\_\_\_\_
- 2) If the patient has failed, had adverse reactions, or contraindications to the above formulary alternative(s), provide clinical details as to what occurred:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*Please note: Submit chart documentation/medical records to support the information you have provided above**

**For Admelog vials, also answer the following (does NOT apply to Admelog SoloStar):**

Is Admelog administered using an infusion pump?  **Yes**  **No**

Was the infusion pump paid for by Medicare?  **Yes**  **No**

Is the patient using a subcutaneous insulin pump [excluding disposable drug delivery systems (e.g., OmniPod, V-Go)]?  **Yes**  **No**

Is the patient enrolled in a comprehensive diabetes program with one of the following symptoms?  **Yes**  **No**

- Dawn phenomenon
- Fluctuations in blood glucose
- Hemoglobin level (HbA1C) greater than 7 percent
- History of recurring hypoglycemia
- History of severe glycemc excursions

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This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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# Admelog & Admelog<sup>®</sup> SoloStar<sup>®</sup> Prior Authorization Request Form (Page 2 of 2)

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Has the patient been on an external insulin infusion pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day?  Yes  No

Does the patient have a fasting blood sugar less than or equal to 225mg/dL?  Yes  No

Does the patient have a Beta cell autoantibody test that is positive?  Yes  No

**Select ONE of the following:**

Admelog is administered at home (not including facility providing skilled nursing care)

The patient is in a long-term care (LTC) facility (e.g., hospital or skilled nursing facility where patient is receiving skilled care)

**Prescriber attestation:**

Does the prescriber attest that the information provided on this form is true and accurate?  Yes  No

**Prescriber signature:** \_\_\_\_\_ Date: \_\_\_\_\_

(Please note: if a non-formulary exception is approved, the requested drug will process at the **highest** brand tier copay for the plan year)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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