HYPOGLYCEMICS, DPP-4 INHIBITORS PRIOR AUTHORIZATION FORM

(form effective 1/1/2026)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:
Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	DX code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL REQUESTS

1. For ALL DPP-4 INHIBITORS:

☐ Tried and failed therapy with metformin.
☐ Has a contraindication or intolerance to metformin.
List contraindication or explain beneficiary's intolerance:_____

2. For a NON-PREFERRED DPP-4 INHIBITOR:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, DPP-4 INHIBITORS that are approved or medically accepted for the beneficiary's diagnosis or indication *(Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.)*
List preferred medications tried:_____
List contraindication or explain beneficiary's intolerance:_____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: