

**HYPOGLYCEMICS, DPP-4 INHIBITORS  
PRIOR AUTHORIZATION FORM**  
(form effective 1/1/2026)



**Keystone First**

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request	<input type="checkbox"/> 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 ( <i>submit documentation</i> ):		DX code ( <i>required</i> ):	

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

INITIAL REQUESTS
<p><b>1. For ALL DPP-4 INHIBITORS:</b></p> <p><input type="checkbox"/> Tried and failed therapy with metformin.</p> <p><input type="checkbox"/> Has a contraindication or intolerance to metformin.</p> <p>List contraindication or explain beneficiary's intolerance: _____</p> <p><b>2. For a NON-PREFERRED DPP-4 INHIBITOR:</b></p> <p><input type="checkbox"/> 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 (<i>Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred Hypoglycemics, DPP-4 inhibitors.</i>)</p> <p>List preferred medications tried: _____</p> <p>List contraindication or explain beneficiary's intolerance: _____</p>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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