

Lantidra (donislecel-jujn)

Member and Medication Information	
* indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength: <input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information	
* indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information	
* indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at 855-828-4992 , to prevent processing delays.	

Criteria for Approval: *(ALL of the following criteria must be met)*

- The medication is prescribed by or in consultation with an endocrinologist with a specialty in islet cell transplantation
- The patient is 18 years of age or older
- The patient is not pregnant
- The patient has a diagnosis of Type 1 Diabetes
- The patient is unable to achieve target HbA1c despite intensive diabetes management (including multiple daily injections, the use of insulin pumps and continuous glucose monitor) and education
- The patient has been compliant with the use of continuous glucose monitoring and insulin regimen
- The patient has a history of current repeated episodes of hypoglycemic unawareness and severe hypoglycemia (defined as at least 1 episodes of severe hypoglycemia in the previous 3 years that require necessitating aid from another person)
- Patient is able to receive concomitant immunosuppression and Pneumocystis jirovecii pneumonia (PCP) and cytomegalovirus (CMV) prophylaxis after each infusion
- The patient is up to date with all vaccinations, in accordance with current vaccination guidelines, prior to initiating therapy
- The patient does not have a history of liver disease, renal failure or has been the recipient of renal transplant.

UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Initial Authorization: One (1) infusion

Re-authorization: Repeated infusions (up to 2) may be performed if the patient does not achieve independence from exogenous insulin within one year of infusion or within one year after losing independence from exogenous insulin after a previous infusion. **Maximum 3 lifetime infusions.**

Note:

Use appropriate HCPCS code for billing

Coverage and Reimbursement code look up: <https://health.utah.gov/stplan/lookup/CoverageLookup.php>

HCPCS NDC Crosswalk: <https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php>

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature

Date