

Pharmacy Prior Authorization Form

Last Reviewed: May 2011

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Januvia (sitagliptin)/ Onglyza (saxagliptin)

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Medication and Requested Dose:

- | | |
|---|---|
| <input type="checkbox"/> Januvia 100mg once daily (CrCl >50ml/min) | <input type="checkbox"/> Onzglyza 2.5mg |
| <input type="checkbox"/> Januvia 50mg once daily (CrCl 30-50ml/min) | <input type="checkbox"/> Onglyza 5mg |
| <input type="checkbox"/> Januvia 25mg once daily (CrCl <30ml/min) | |

Priority Health precertification requirements:

Authorization requires:

- Diagnosis of type 2 diabetes
- Documented therapeutic trial of at least 1500 mg or maximally effective &/or tolerated dose of metformin per day for at least 3 months within the past 4 months

Please Complete the Following Information:

- Type 2 diabetes
- Patient is taking at least 1500 mg of metformin per day for 3 of the past 4 months

OR

- Is on maximally effective &/or tolerated dose of metformin (less than 1,500mg for at least 3 of the last 4 months)
- Patient has contraindication to, allergy to, renal impairment (CLcr < 60-70 ml/min) or cannot tolerate metformin
- Other rationale if the above criteria are not met: _____

For Medicare only: If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
- The number of doses available under a dose restriction for the prescription drug:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
 - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance

- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
 - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

*** All fields must be complete and legible for Prior Authorization Review***
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX