PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial** ☒ **Commercial Individual (PPACA)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. The standard review time averages between 1 and 3 business days.

Jardiance (empagliflozin), **Xigduo XR** (dapagliflozin/metformin), **Glyxambi** (empagliflozin/linagliptin)

Reset Form

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: ☐ Glyxambi ☐ Jardiance ☐ Xigduo XR

Start date (or date of next dose): _____

Dose Requested: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of type 2 diabetes
2. Trial, failure, or intolerance to metformin plus a formulary sulfonylurea, thiazolidinedione (TZD), or dipeptidyl peptidase-4 (DPP-4) inhibitor.
3. Hemoglobin A1c less than or equal to 9%

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Type 2 diabetes

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. What other treatments has the patient tried in the last 120 days?

☐ Metformin	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Glipizide	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Glimiperide	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Glyburide	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Pioglitazone	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Januvia	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Janumet	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Trajenta	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:
☐ Jentadueto	☐ **Current**	☐ **Discontinued, Reason**		**Duration**:

All fields must be complete and legible for review. Your office will receive a response via fax. New 11/2016

C. What is the patient's most recent Hemoglobin A1c?

☐ Date_____ ☐ Result_____

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax. New 11/2016