PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **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.

Invokana (canagliflozin), **Invokamet/XR** (canaglifozin/metformin), **Jardiance** (empagliflozin), **Synjardy/XR**(empagliflozin/metformin) **Steglatro** (ertugliflozin), **Segluromet**(ertugliflozin/metformin)

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

☐ New request ☐ Continuation request

Drug product:

☐ Invokana ☐ Jardiance

☐ Invokamet ☐ Synjardy

☐ Invokamet XR ☐ Synjardy XR

☐ Steglatro ☐ Segluromet

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%

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 05/2019

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 is the patient's most recent Hemoglobin A1c?

☐ Date_____ ☐ Result_____

C. 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**:_____

☐ Tradjenta ☐**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. No changes made since 09/2018

Last reviewed 05/2019