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) **Farxiga** (dapaglifozin) , **Xigduo XR** (dapagliflozin/metformin), **Jardiance** (empagliflozin), **Glyxambi** (empagliflozin/linagliptin) **Synjardy/XR** (empagliflozin/metformin), **Qtern** (Dapagliflozin/saxagliptin) **Steglatro** (ertugliflozin), **Steglujan** (ertugliflozin/sitagliptin), **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

Preferred Drug product:

- ☐ Synjardy/XR
- ☐ Glyxambi
- ☐ Farxiga
- ☐ Xigduo XR
- ☐ Jardiance

Start date (or date of next dose): ______________________

Dose Requested: ______________________

Non- Preferred Drug product:

- ☐ Steglatro
- ☐ Steglujan
- ☐ Segluromet
- ☐ Invokana
- ☐ Invokamet/XR
- ☐ Qtern

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2018
Last reviewed 05/2019

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. Non-preferred drug product: Trial and failure, or intolerance to one of the preferred products after 3 continuous months of receiving maximal daily doses and not achieving adequate glycemic control.
4. 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 is the patient's most recent Hemoglobin A1c?

☐ Date____________ ☐ Result___________
☐ *Other – the patient's condition is:* ______________________________
Rationale for use: ______________________________

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

☐ Metformin ☐**Current** ☐ **Discontinued, Reason:**_____________________ **Duration**:_________________
☐ Glipizide ☐**Current** ☐ **Discontinued, Reason:**_____________________ **Duration**:________________
☐ Glimepiride ☐**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**:_________________

D. If requesting a non-preferred product, what preferred product has the patient tried?

☐ Invokana ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________
☐ Invokamet ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________
☐ Farxiga ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________
☐ Xigduo ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________
☐ Jardiance ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________
☐ Glyxambi ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________
☐ Synjardy ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________
☐ Qtern ☐**Current** ☐ **Discontinued, Reason:**______________________ **Duration**:_______________