PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Farxiga - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Farxiga - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Farxiga (dapagliflozin)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Is there documentation showing beneficial response to treatment? Y N _____

[Note: Documentation must be submitted.]

	[No further questions.]		
3.	Is the patient 18 years of age or older?	Y N	
	[If no, then no further questions.]		
4.	Does the patient have any of the following: A) Type 1 diabetes mellitus or diabetic ketoacidosis, B) Dialysis, C) History of hypersensitivity reactions to Farxiga, D) Severe renal impairment (eGFR [estimated glomerular filtration rate] less than 30mL/min), E) Second and third trimesters of pregnancy, or breast-feeding, F) Concurrent use with another SGLT2 Inhibitor?	Y N	
	[If yes, then no further questions.]		
5.	Does the patient have a diagnosis of type 2 diabetes?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then skip to question 12.]		
6.	Is the requested drug being prescribed for glycemic control?	Y N	
	[If no, then skip to question 9.]		
7.	Is Farxiga being used as adjunct therapy to diet and exercise?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
8.	Has the patient had prior trial and inadequate response, or intolerance to at least two formulary sodium-glucose cotransporter 2 (SGLT2) inhibitors (Jardiance, Steglatro, etc.)?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
9.	Is the requested drug being prescribed for hospitalization risk reduction?	Y N	
	[If no, then no further questions.]		
10.	Is Farxiga being used to reduce the risk of hospitalization due to heart failure?	Y N	
	[If no, then no further questions.]		
11.	Does the patient have established cardiovascular disease, or at least two of the following cardiovascular risk factors: A) Age (55 years and older for men, or 60 years and older for women), B) Dyslipidemia, C) Hypertension, D) Current tobacco use?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
12.	Is the requested drug being prescribed for heart failure?	Y N	
	[If no, then no further questions.]		

13.	Has documentation been submitted showing all the following: A) Patient has a diagnosis of chronic heart failure with clinical symptoms (New York Heart Association [NYHA] functional class II, III, or IV), B) Left ventricular ejection fraction of 40 percent or less, C) Elevated B-type natriuretic peptide levels, D) Patient is on a current therapy regimen consistent with the standards of care (ACE Inhibitors, ARBs, ARNI, beta blockers, diuretics, etc)?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date