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

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

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)

Dapagliflozin 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.	Is this request for any of the following: A) Patient with type 1 diabetes mellitus or diabetic ketoacidosis, B) Patient on dialysis, C) Patient with a history of hypersensitivity reactions to product ingredients, D) Patient that is in the second or third trimester of pregnancy, or breast-feeding, E) Concurrent use with another SGLT2 Inhibitor, F) Any indications or usage that is not FDA-approved, or guideline-supported?	Y N
	[If yes, then no further questions.]	
5.	Has documentation been submitted showing the patient has a diagnosis of type 2 diabetes?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then skip to question 13.]	
6.	Is the requested drug being prescribed for glycemic control in Diabetes Mellitus?	Y N
	[If no, then skip to question 9.]	
7.	Is the requested drug being prescribed 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 a 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 in Diabetes Mellitus?	Y N
	[If no, then no further questions.]	
10.	Is the requested drug being prescribed to reduce the risk of hospitalization due to heart failure?	Y N
	[Note: Documentation must be submitted.]	
	[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.]		
[If no, then no further questions.]		
12. Has the patient been established on an antidiabetes medication regimen?	Y N	
[No further questions.]		
13. Is the requested drug being prescribed for the treatment of heart failure?	Y N	
[If no, then skip to question 16.]		
14. Has documentation been submitted showing the patient has a diagnosis of chronic heart failure with clinical symptoms (New York Heart Association [NYHA] functional class II, III, or IV)?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
15. Has the patient had a trial and inadequate response or contraindication to empagliflozin therapy?	Y N	
[Note: Documentation must be submitted.]		
[No further questions.]		
16. Is the requested drug being prescribed for the treatment of Chronic Kidney Disease (CKD)?	Y N	
[If no, then no further questions.]		
17. Has documentation been submitted showing all of the following: A) eGFR greater than 25 mL/min/1.73 square meters, B) Evidence of increased albuminuria (urine albumin creatinine ratio (UACR) between 200 and 5000 mg/g), C) Patient has been established on a medication regimen with an ACE inhibitor (e.g., lisinopril) or ARB (e.g., losartan) unless contraindicated?	Y N	
[Note: Documentation must be submitted.]		

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