



Prior Authorization
<p style="text-align: center;"><b>JOHNS HOPKINS HEALTH PLANS</b> Synjardy, Synjardy XR - Priority Partners MCO</p> <p style="text-align: center;">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 <b>1-410-424-4607</b>. Please contact Johns Hopkins Health Plans at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process.</p> <p style="text-align: center;">When conditions are met, we will authorize the coverage of Synjardy, Synjardy XR - Priority Partners MCO.</p>

Drug Name (select from list of drugs shown)		
Synjardy (empagliflozin-metformin)      Synjardy XR (empagliflozin-metformin ER)		
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:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Is this request for continuation of therapy?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
3. 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then no further questions.]	
4. Has documentation been submitted showing the patient has a diagnosis of type 2 diabetes?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then skip to question 15.]	
5. Is the requested drug being prescribed for glycemic control in Diabetes Mellitus?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 12.]	
6. Is the requested drug being prescribed as adjunct therapy to diet and exercise?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
7. Has the patient had a trial and inadequate response, intolerance, or contraindication to metformin?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
8. Is this request for Synjardy XR (empagliflozin/metformin extended-release)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 11.]	
9. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
10. Has the patient had a trial and inadequate response or contraindication to Steglatro (ertugliflozin)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
11. Is the patient 10 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
12. Is the requested drug being prescribed for cardiovascular death risk reduction in established cardiovascular disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	

13. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
14. Has documentation been submitted showing a history of at least one of the following: A) Coronary artery disease, B) Stroke, C) Peripheral artery disease, D) Heart failure?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
15. Is the requested drug being prescribed for the treatment of heart failure?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
16. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
17. Has documentation been submitted showing that the patient has a diagnosis of chronic heart failure with clinical symptoms (New York Heart Association [NYHA] functional class II, III, or IV)?	<input type="checkbox"/> Y <input type="checkbox"/> 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.

<b>Prescriber (Or Authorized) Signature and Date</b>