TRICARE Prior Authorization Request Form for
sotagliflozin (**Inpefa)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. The provider is aware and acknowledges that empagliflozin (Jardiance), empagliflozin/metformin (Synjardy, Synjardy XR) and empagliflozin/linagliptin (Glyxambi) are DoD's preferred SGLT2 inhibitor, and that prior authorization is not required for empagliflozin.	☐ Acknowledged Proceed to question **2**	
2. The provider is aware and acknowledges that empagliflozin (Jardiance) is FDA-approved for patients with heart failure at all levels of ejection fraction and is approved for patients with chronic kidney disease.	☐ Acknowledged Proceed to question **3**	
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. What is the indication or diagnosis? Note: Non-FDA-approved uses are not approved, including type 1 diabetes mellitus, heart failure with preserved ejection fraction, or acute decompensated heart failure.	☐ Reduce the risk of cardiovascular death, hospitalization for heart failure and urgent heart failure visits in patients with heart failure, type 2 diabetes, chronic kidney disease and other cardiovascular risk factors - Proceed to question **5** ☐ Other - **STOP Coverage not approved**	
5. Has the patient experienced significant adverse reactions empagliflozin?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to empagliflozin?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the prescription written by or in consultation with a cardiologist?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving appropriate guideline-directed medical therapy including the following: angiotensin-converting enzyme inhibitor (ACEI), angiotensin II receptor blocker (ARB), or angiotensin receptor neprilysin inhibitor (ARNI); beta blocker; and aldosterone antagonist, unless contraindicated or if the patient has experienced adverse effects or could not tolerate these therapies?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[15 Nov 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: