TRICARE Prior Authorization Request Form for

canagliflozin **(Invokana) –** dapagliflozin **(Farxiga) –** ertugliflozin **(Steglatro) –** ertugliflozin/sitagliptin (**Steglujan**) **–** bexagliflozin **(Brenzavvy)**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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

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

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

PA 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. Is the patient greater than or equal to 18 year(s) of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**	
2. 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 PA is not required for empagliflozin.	☐ Acknowledged Proceed to question **3**		
3. 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.	☐ Improved glycemic control in patient with Type 2 Diabetes Mellitus - Proceed to question **4** ☐ Reduce the risk of cardiovascular death in patients with Type 2 Diabetes Mellitus AND established cardiovascular disease - Proceed to question **4** ☐ Reduce kidney disease progression and improve cardiovascular outcomes in patients with Chronic Kidney Disease - Proceed to question **6** ☐ Reduce risk of heart failure hospitalization and/or cardiovascular death in patients with Heart Failure with reduced ejection fraction (HFrEF) - Proceed to question **11** ☐ Other - **STOP Coverage not approved**		
4. Has the patient experienced inadequate response, significant adverse effects, or have a contraindication to metformin?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**	

5. Has the patient experienced inadequate response, significant adverse effects, or have a contraindication to a preferred SGLT2 inhibitor? The preferred SGLT2 inhibitors are Jardiance, Synjardy, Synjardy XR, and Glyxambi	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**	
6. Is the initial prescription written by or in consultation with a nephrologist?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**	
7. Has the patient experienced significant adverse reactions or have a contraindication to empagliflozin?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**	
8. Is the patient's estimated glomerular filtration rate (eGFR) higher than 25 ml/min/1.73m2?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**	
9. Is the patient's Urinary Albumin-to-Creatinine Ratio greater than or equal to 200 mg/gram?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**	
10. Is the patient receiving maximum tolerated labeled dose of an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor blocker (ARB), or is unable to use an ACEI or ARB?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**	
11. Has the patient experienced significant adverse reactions or has a contraindication to empagliflozin?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**	
12. Is the initial prescription written by or in consultation with a cardiologist?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**	
13. Does the patient have a documented diagnosis of chronic HF (NYHA II-IV) with a left ventricular ejection fraction (LVEF) less than or equal to 40% and with continued heart failure symptoms?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**	
14. 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 _____

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