Prior Authorization Request Form for
alogliptin + metformin (**Kazano**), linagliptin + metformin (**Jentadueto**),
saxagliptin + metformin (**Kombiglyze XR**)

JOHNS HOPKINS MEDICINE
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USFHP Pharmacy Prior Authorization Form

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

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.

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. Has the patient tried at least ONE of the following and failed to achieve glycemic control: METFORMIN (alone or in combination) **or a SULFONYLUREA** (alone or in combination)**?**	☐ Yes **SKIP** to question **4**	☐ No Proceed to question **2**
2. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	☐ Yes **SKIP** to question **4**	☐ No Proceed to question **3**
3. Does the patient have a contraindication to a sulfonylurea?	☐ Yes **SKIP** to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient experienced an adverse event with a sitagliptin-containing product (i.e., a product that contains Januvia) **which is not expected to occur with an alogliptin-, saxagliptin- or linagliptin-containing product** (i.e., a product containing Nesina, Onglyza, or Tradjenta)**?**	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Has the patient experienced an inadequate response to a sitagliptin-containing product (i.e., a product that contains Januvia)**?**	☐ Yes **Sign and date below**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to sitagliptin (i.e., Januvia) **which is not expected to exist with an alogliptin-, saxagliptin- or linagliptin-containing product?**	☐ Yes **Sign and date below**	☐ No **Coverage not approved**

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

_____ _____
Prescriber Signature Date

[3 July 2013]

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