Prior Authorization Request Form for Dapagliflozin; Saxagliptin (Qtern)



FAX Completed Form and Applicable Progress Notes to:

(410) 424-4037

HEALTHCARE 7231 Parkway Drive, Suite 100, Hanover, MD 21076

KINS 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.

PLEASE NOTE: Sitagliptin is the preferred DPP-4 and empagliflozin is the preferred SGLT2

| Please complete patient and physician information (please print): | | | | | | | |
|--|--|---|---|---|--|--|--|
| Patient Name: | Physician Name: | | | | | | |
| Address: | | Address: | | | | | |
| | | | | | | | |
| | | Secure Fax #: | cure Fax #: | | | | |
| Please complete the clinical assessment: | | | | | | | |
| 1. Has the patient had an inadequate response to metformin? | | | Yes | 🗆 No | | | |
| | | Proceed to | o question 4 | Proceed to question 2 | | | |
| 2. Has the patient experienced a significant adverse effect from metformin? | | t 🗆 | Yes | 🗆 No | | | |
| | | Proceed to | o question 4 | Proceed to question 3 | | | |
| 3. Does the patient have a contraindication to metformin | | | Yes | 🗆 No | | | |
| | | Proceed to | o question 4 | STOP | | | |
| | | | | Coverage not approved | | | |
| Has the patient tried one of the preferred products (Jardiance, Glyxambi, Synjardy, Synjardy XR) and experienced a significant adverse event that is not | | | Yes | 🗆 No | | | |
| | | Proceed to | o question 5 | STOP | | | |
| expected to occur with the requested agent? | | | Coverage not approved | | | | |
| 5. Has the patient experienced an adverse event with a | | Yes | 🗆 No | | | | |
| contains Januvia), which is not expected to occur wit alogliptin-, saxagliptin-, or linagliptin-containing | | Sign and | date below | Proceed to question 6 | | | |
| | | | | | | | |
| | Patient Name: Address: Sponsor ID # Date of Birth: Please complete the c 1. Has the patient had a metformin? 2. Has the patient experfrom metformin? 3. Does the patient tried of (Jardiance, Glyxambi experienced a signific expected to occur with sitagliptin-containing contains Januvia), whalogliptin-, saxagliptin products (that is, | Patient Name: Phy Address: Phy Sponsor ID # Please complete the clinical assessment: 1. Has the patient had an inadequate response to metformin? S 2. Has the patient experienced a significant adverse effect from metformin? S 3. Does the patient have a contraindication to metformin? S 4. Has the patient tried one of the preferred products (Jardiance, Glyxambi, Synjardy, Synjardy XR) and experienced a significant adverse event that is not expected to occur with the requested agent? 5. Has the patient experienced an adverse event with a sitagliptin-containing product (that is, a product that contains Januvia), which is not expected to occur with alogliptin-, saxagliptin-, or linagliptin-containing products (that is, products containing Nesina, Onglyza) | Patient Name: Physician Name: Address: Address: Address: Address: Sponsor ID # Phone #: Date of Birth: Secure Fax #: Please complete the clinical assessment: Image: Secure Fax #: 1. Has the patient had an inadequate response to metformin? Proceed to 2. Has the patient experienced a significant adverse effect from metformin? Proceed to 3. Does the patient have a contraindication to metformin? Proceed to 4. Has the patient tried one of the preferred products (Jardiance, Glyxambi, Synjardy, Synjardy XR) and experienced a significant adverse event that is not expected to occur with the requested agent? Proceed to 5. Has the patient experienced an adverse event with a sitagliptin-containing product (that is, a product that contains Januvia), which is not expected to occur with alogliptin-, or linagliptin-containing products (that is, products containing Nesina, Onglyza Sign and | Patient Name: Physician Name: Address: Address: Sponsor ID # Phone #: Date of Birth: Secure Fax #: Please complete the clinical assessment: Image: Proceed to question 4 1. Has the patient had an inadequate response to metformin? Image: Proceed to question 4 2. Has the patient experienced a significant adverse effect from metformin? Image: Proceed to question 4 3. Does the patient have a contraindication to metformin? Image: Proceed to question 4 4. Has the patient tried one of the preferred products (Jardiance, Glyxambi, Synjardy, Synjardy XR) and experienced a significant adverse event that is not expected to occur with the requested agent? Image: Proceed to question 5 5. Has the patient experienced an adverse event with a sitagliptin-containing product (that is, a product that contains Januvia), which is not expected to occur with alogliptin-, saragliptin-, or linagliptin-containing products (that is, products containing Nesina, Onglyza Image: Proceed to question 5 | | | |

Continue on next page

| | 6. Has the patient had an inadequate response to a sitagliptin-containing product (that is, a product that contains Januvia)? | ☐ Yes Sign and date below | No Proceed to question 7 |
|-----------|--|------------------------------|---------------------------------------|
| | 7. Does the patient have a contraindication to sitagliptin (that is, Januvia) which is not expected to occur with an alogliptin-, saxagliptin- or linagliptin-containing product? | ☐ Yes Sign and date below | □ No STOP Coverage not approved |
| Step 3 | I certify the above is true to the best of my knowledge. Pleas | e sign and date: | |

Prescriber Signature

Date

[04 December 2017]

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