Prior Authorization Request Form for
Dapagliflozin; Saxagliptin **(Qtern)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

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

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 had an inadequate response to metformin?	☐ Yes Proceed to question 4	☐ No Proceed to question 2
2. Has the patient experienced a significant adverse effect from metformin?	☐ Yes Proceed to question 4	☐ No Proceed to question 3
3. Does the patient have a contraindication to metformin?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
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?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
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 or Tradjenta)?	☐ Yes **Sign and date below**	☐ No Proceed to question 6

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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. Please 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: