

Prior Authorization Request Form for
 canagliflozin (**Invokana**) – dapagliflozin (**Farxiga**) – ertugliflozin (**Steglatro**) –
 ertugliflozin/sitagliptin (**Steglujan**)



JOHNS HOPKINS
 M E D I C I N E

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 HEALTHCARE

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.

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

1 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?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 2
2. Has the patient experienced a significant adverse effect from metformin?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 3
3. Does the patient have a contraindication to metformin?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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

_____ Date _____
 Prescriber Signature

[05 February 2018]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: