



Prior Authorization
<b>JOHNS HOPKINS HEALTHCARE (MEDICAID)</b> Glyxambi - Priority Partners MCO This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at <b>1-410-424-4607</b> . Please contact Johns Hopkins Healthcare at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Glyxambi - Priority Partners MCO.

Drug Name (select from list of drugs shown) Glyxambi (empagliflozin-linagliptin)
---

Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
-------------------------	------------------------

Comments: _____
-----------------

<b>Please circle the appropriate answer for each question.</b>	
1. Does the patient have any of the following: A) Severe renal impairment, end-stage renal disease, or dialysis, B) History of hypersensitivity reaction to Glyxambi or any of its components, C) Type 1 diabetes, D) History of reoccurring genitourinary infections, E) Acute pancreatitis?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then no further questions.]	
2. Is the requested drug being prescribed for adjunct therapy in an adult patient with type 2 diabetes?	<input type="checkbox"/> Y <input type="checkbox"/> N

[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
3. Has the patient had trial and failure of a formulary dipeptidyl peptidase-4 (DPP-4) inhibitor?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If yes, then no further questions.]	
4. Has the patient had trial and failure of a formulary sodium-glucose co-transporter (SGLT-2) inhibitor?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>