PRIOR AUTHORIZATION REQUEST
DPP4 Inhibitors

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Is the patient CURRENTLY taking metformin?
2. ☐ Yes ☐ No Did the patient have a previous inadequate response or adverse effect to metformin?
3. ☐ Yes ☐ No Does the patient have any of the following contraindications to metformin: A) Renal dysfunction (serum creatinine greater than 1.4mg per dL for females or greater than 1.5mg per dL for males), B) Metabolic acidosis, C) Diabetic ketoacidosis?
4. ☐ Yes ☐ No Has the patient tried and failed ONE of the following preferred formulary DPP4 inhibitors: alogliptin benzoate, alogliptin-pioglitazone.
5. Please list medications all tried and reason for medication failure.

_____

_____

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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If you have any questions, call: 800-753-2851

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authorization as per Plan policy and procedures.

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