maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

DPP4 Inhibitors

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 What drug is being requested?

[] Linagliptin (Tradjenta) (If checked, go to 2)

[] Sitagliptin (Januvia, Zituvio) (If checked, go to 2)

[] Saxagliptin (Onglyza) (If checked, go to 2)

[] Saxagliptin-metformin (Kombiglyze XR) (If checked, go to 2)

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[] Sitagliptin-metformin (Janumet) (If checked, go to 2)

[] Linagliptin-metformin (Jentadueto) (If checked, no further questions)

2	Is the patient CURRENTLY taking metformin? [If yes, skip to question 5.]	Yes	No
3	Did the patient have a previous inadequate response or adverse effect to metformin? [If yes, skip to question 5.]	Yes	No
4	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? [If no, no further questions.]	Yes	No
5	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
6	Has the patient tried and failed ONE of the following preferred formulary dipeptidyl peptidase-4 (DPP4) inhibitors: A) alogliptin benzoate, B) alogliptin-pioglitazone, C) alogliptin-metformin? If yes, please list all medications tried and reason for medication failure _____.	Yes	No

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: 1-833-896-0656

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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use,

If you have any questions, call: 1-888-258-8250

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