PRIOR AUTHORIZATION REQUEST

SGLT2 Inhibitor Products

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	Has the patient received prior authorization for this medication in the last year from MPC? [If no, skip to question 5.]	Yes	No
2	Is the requested drug a Multisource Brand? [NOTE: The definition of a Multisource Brand is a brand name drug for which a generic is available.] [If no, skip to question 4.]	Yes	No

PRIOR AUTHORIZATION REQUEST

3	Did the patient experience intolerance, adverse side effect, or treatment failure to the generic formulation made by two different manufacturers? [If no, no further questions.]	Yes	No
4	Is the patient responding to therapy? [No further questions.]	Yes	No
5	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
6	What is the patient's diagnosis? [] Chronic Kidney Disease (If checked, go to 7) [] Heart Failure (If checked, go to 12) [] Diabetes Mellitus (If checked, go to 21)		
7	Does the patient have a diagnosis of autosomal recessive polycystic kidney disease, lupus nephritis or antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis? [If yes, no further questions.]	Yes	No
8	Is the patient receiving maximally tolerated treatment with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB)? [If yes, skip to question 10.]	Yes	No
9	Did the patient experience clinically significant adverse effects from treatment with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB)? [If no, no further questions.]	Yes	No
10	Is the request for dapagliflozin, Steglatro or Segluromet? [If yes, no further questions.]	Yes	No
11	Has the patient tried the preferred formulary alternatives dapagliflozin, Steglatro or Segluromet? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of heart failure (HF) of New York Heart Association (NYHA) Class II, III or IV? [If no, no further questions.]	Yes	No
13	Is the medication being prescribed by or in consultation with a cardiologist? [If no, no further questions.]	Yes	No
14	What type of heart failure does the patient have? [] Heart failure with reduced ejection fraction (HFrEF) (If checked, go to 15)		

PRIOR AUTHORIZATION REQUEST

	[] Heart failure with preserved ejection fraction (HFpEF) (If checked, go to 16)		
15	Does the patient have a left ventricular ejection fraction (LVEF) less than or equal to 40%? [If no, no further questions.]	Yes	No
16	Does the medication requested contain dapagliflozin or empagliflozin? [If no, no further questions.]	Yes	No
17	Is the patient receiving maximally tolerated treatment for heart failure (HF) with an angiotensin-converting enzyme inhibitor (ACEi), angiotensin receptor blocker (ARB), beta-blockers, mineralocorticoid receptor antagonists (MRA) and diuretics? [If yes, skip to question 19.]	Yes	No
18	Did the patient experience clinically significant adverse effects from treatment with an angiotensin-converting enzyme inhibitor (ACEi), angiotensin receptor blocker (ARB), beta-blockers, mineralocorticoid receptor antagonists (MRA) and diuretics? [If no, no further questions.]	Yes	No
19	Is the request for dapagliflozin, Steglatro or Segluromet? [If yes, no further questions.]	Yes	No
20	Has the patient tried the preferred formulary alternatives dapagliflozin, Steglatro or Segluromet? [No further questions.]	Yes	No
21	Does the patient have Type 1 Diabetes Mellitus? [If yes, no further questions.]	Yes	No
22	Does the patient have Type 2 Diabetes Mellitus? [If no, no further questions.]	Yes	No
23	Is the request for dapagliflozin, Steglatro or Segluromet? [If yes, no further questions.]	Yes	No
24	Has the patient tried the preferred formulary alternatives dapagliflozin, Steglatro or Segluromet?	Yes	No

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

_____

_____

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

Version 07.2025

PRIOR AUTHORIZATION REQUEST

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, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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

Version 07.2025