



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? <input type="checkbox"/> Linagliptin (Tradjenta) (If checked, go to 2) <input type="checkbox"/> Sitagliptin (Januvia, Zituvio) (If checked, go to 2) <input type="checkbox"/> Saxagliptin (Onglyza) (If checked, go to 2) <input type="checkbox"/> Saxagliptin-metformin (Kombiglyze XR) (If checked, go to 2)
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**If you have any questions, call:
1-888-258-8250**

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

Linagliptin-metformin (Jentadueto) (If checked, go to 2)

2 Is the request an INITIAL or CONTINUATION of therapy?

Initial (If checked, go to 8)

Continuation (If checked, go to 3)

3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
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4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
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5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
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6	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 8.]	Yes	No
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7	Has documentation been provided to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
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8	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
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9	Is the patient CURRENTLY taking metformin? [If yes, skip to question 12.]	Yes	No
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10	Did the patient have a previous inadequate response or adverse effect to metformin? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 12.]	Yes	No
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11	Does the patient have any of the following contraindications to metformin: A) Renal dysfunction (serum creatinine greater than 1.4 mg per dL for females or greater than 1.5 mg per dL for males, estimated glomerular filtration rate [eGFR] below 30 mL/min/1.73 m ²), B) Metabolic acidosis, C) Diabetic ketoacidosis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
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12	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? ACTION REQUIRED: Submit supporting documentation.	Yes	No
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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.

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