



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 | Is this request for initial therapy or for continuation of therapy? | | |
| | ☐ Initial (If checked, go to 9) | | |
| | ☐ Continuation (If checked, go to 2) | | |
| 2 | Is the patient currently receiving the requested medication? | Yes | No |
| | [If no, skip to question 9.] | | |

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 9.]	Yes	No
4	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 9.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 9.]	Yes	No
6	Is the requested medication 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 8.]	Yes	No
7	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
8	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
9	What is the patient's diagnosis? ☐ Chronic Kidney Disease (If checked, go to 10) ☐ Heart Failure (If checked, go to 16) ☐ Diabetes Mellitus (If checked, go to 26) ☐ Other (If checked, no further questions)		
10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
11	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
12	Is the patient receiving maximally tolerated treatment with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB)? [If yes, skip to question 14.]	Yes	No

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13	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
14	Is the request for dapagliflozin, Steglatro or Segluromet? [If yes, no further questions.]	Yes	No
15	Has the patient tried the preferred formulary alternatives dapagliflozin, Steglatro or Segluromet? [No further questions.]	Yes	No
16	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
17	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
18	Is the requested medication being prescribed by or in consultation with a cardiologist? [If no, no further questions.]	Yes	No
19	What type of heart failure does the patient have? ☐ Heart failure with reduced ejection fraction (HFrEF) (If checked, go to 20) ☐ Heart failure with preserved ejection fraction (HFpEF) (If checked, go to 21)		
20	Does the patient have a left ventricular ejection fraction (LVEF) less than or equal to 40%? [If no, no further questions.]	Yes	No
21	Does the requested medication contain dapagliflozin or empagliflozin? [If no, no further questions.]	Yes	No
22	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 24.]	Yes	No
23	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

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24	Is the request for dapagliflozin, Steglatro or Segluromet? [If yes, no further questions.]	Yes	No
25	Has the patient tried the preferred formulary alternatives dapagliflozin, Steglatro or Segluromet? [No further questions.]	Yes	No
26	Does the patient have Type 1 Diabetes Mellitus? [If yes, no further questions.]	Yes	No
27	Does the patient have Type 2 Diabetes Mellitus? [If no, no further questions.]	Yes	No
28	Is the request for dapagliflozin, Steglatro or Segluromet? [If no, skip to question 32.]	Yes	No
29	What is the requested medication? ☐ Dapagliflozin (If checked, go to 30) ☐ Steglatro (If checked, go to 31) ☐ Segluromet (If checked, go to 31)		
30	Is the patient greater than or equal to 10 years of age? [No further questions.]	Yes	No
31	Is the patient greater than or equal to 18 years of age? [No further questions.]	Yes	No
32	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:

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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.

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