pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HYPOGLYCEMICS, SGLT2 INHIBITORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hypoglycemics, SGLT2 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested (clinical prior authorization required):	☐Glyxambi tablet ☐Jardiance tablet	☐Synjardy tablet ☐Synjardy XR tablet	
Non-preferred medication requested:	☐Farxiga tablet ☐Invokamet tablet ☐Invokamet XR tablet ☐Invokana tablet	☐Qtern tablet ☐Segluromet tablet ☐Steglatro tablet	☐Steglujan tablet ☐Xigduo XR tablet ☐_____

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis *(submit documentation)*:	Dx code (*required*):

1. Does the beneficiary have a diagnosis of type 2 diabetes?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
2. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of maximum tolerated doses of **metformin**?	☐Yes ☐No *Submit documentation showing trial and failure of, or contraindication or intolerance to, metformin (including result of a recent HbA1c).*
3. ***Requests for NON-PREFERRED agents only:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred SGLT2 Inhibitors? *Check all that apply.* ☐Glyxambi tablet ☐Synjardy tablet ☐Jardiance tablet ☐Synjardy XR tablet	☐Yes ☐No *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: