

HYPOGLYCEMICS, SGLT2 INHIBITORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Hypoglycemics, SGLT2 Inhibitors** and **Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name: _____		
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____			NPI: _____	MA Provider ID#: _____	
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

CLINICAL INFORMATION

Preferred medication requested (clinical prior authorization required):		<input type="checkbox"/> Invokana tablet
Non-preferred medication requested:		<input type="checkbox"/> Farxiga tablet <input type="checkbox"/> Jardiance tablet <input type="checkbox"/> Xigduo XR tablet <input type="checkbox"/> Invokamet tablet <input type="checkbox"/> Synjardy tablet <input type="checkbox"/> _____
Strength: _____	Dose/directions: _____	Quantity: _____ Refills: _____
Diagnosis (<i>submit documentation</i>): _____	Dx code (<i>required</i>): _____	Recipient's weight: _____ lb / kg

All NON-PREFERRED requests

1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred SGLT2 Inhibitor, <u>Invokana</u> ?	<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agent tried and treatment outcomes, including contraindications or intolerances.</i> <input type="checkbox"/> No
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All INITIAL requests

2. What is the Recipient's baseline hemoglobin A1c (HbA1c)? _____	Date: _____ <i>Submit documentation.</i>
3. Does the Recipient have a history of trial and failure, contraindication, or intolerance to <u>maximum tolerated doses of metformin in combination with maximum tolerated doses of other second-line agents</u> for the treatment of DM Type 2 as recommended in the current ADA guidelines? <i>Check all that apply.</i> <input type="checkbox"/> metformin <input type="checkbox"/> DPP-4 inhibitor <input type="checkbox"/> GLP-1 agonist <input type="checkbox"/> sulfonylurea <input type="checkbox"/> thiazolidinedione <input type="checkbox"/> insulin	<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</i> <input type="checkbox"/> No
4. <i>Submit documentation</i> of the following results for the Recipient. <input type="checkbox"/> blood pressure reading <input type="checkbox"/> potassium level <input type="checkbox"/> serum creatinine level <input type="checkbox"/> fasting lipid panel	
5. Do any of the following apply to the Recipient? <i>Check all that apply and submit documentation.</i> <input type="checkbox"/> end-stage renal disease or on dialysis <input type="checkbox"/> taking an anti-hypertensive agent <input type="checkbox"/> active bladder cancer	

All RENEWAL requests

1. What is the Recipient's baseline hemoglobin A1c (HbA1c)? _____	Date: _____ <i>Submit documentation.</i>
2. What is the Recipient's recent hemoglobin A1c (HbA1c)? _____	Date: _____ <i>Submit documentation.</i>

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

Prescriber Signature: _____	Date: _____
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