

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.*

Drug Requested: *SGLT2 (Sodium Glucose Co-Transporter 2) Drugs* **(MEDICAID)**

Non-Preferred Drugs - Check box below that applies:

<i>Non-Preferred with Age Restrictions</i>	
<input type="checkbox"/> Invokamet® (canagliflozin/metformin HC1)	<input type="checkbox"/> Invokamet XR® (canagliflozin/metformin HC1 extended-release) (Age)
<input type="checkbox"/> Segluromet® (ertugliflozin/metformin)	<input type="checkbox"/> Xigduo® XR (dapagliflozin/metformin HC1 extended-release) (Age)
<input type="checkbox"/> Steglatro® (ertugliflozin)	<input type="checkbox"/> Steglujan® (ertugliflozin/sitagliptin)

DRUG INFORMATION: *Complete all information below or authorization process will be delayed.*

Drug Name/Form: _____ **Strength:** _____
Quantity per Day: _____ **Length of therapy:** _____
Diagnosis: _____ **ICD Code, if applicable:** _____
 INITIAL APPROVAL: 6 MONTHS **RENEWALS:** 1 YEAR

CLINICAL/STEP-EDIT CRITERIA - for ALL Non-Preferred SGLT2 Drugs. Age Restriction Applies.

- Patient is ≥ 18 years old
- AND**
- Patient diagnosed with Type 2 diabetes and has been compliant with and has not achieved adequate glycemic control **with a 90 day trial of metformin and HbA1c > 7.6%**
- OR**
- Patient is intolerant to metformin

<i>Preferred Drugs (Age Restrictions): Patient must be ≥ 18 years of age to qualify.</i>		
<input type="checkbox"/> Farxiga® (dapagliflozin)	<input type="checkbox"/> Invokana® (canagliflozin)	<input type="checkbox"/> Jardiance® (empagliflozin)
<input type="checkbox"/> Synjardy® (empagliflozin/metformin HC1)	<input type="checkbox"/> Glyxambi® (empagliflozin/linagliptin)	

Use of samples to initiate therapy **does not meet step-edit/preauthorization criteria.**
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____
Member Optima #: _____ Date of Birth: _____
Prescriber Name: _____
Prescriber Signature: _____ Date: _____
Office Contact Name: _____
Phone Number: _____ Fax Number: _____
DEA OR NPI #: _____