# OPTIMA HEALTH COMMUNITY CARE
# AND
# OPTIMA FAMILY CARE
## (MEDICAID)

### 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)**

**Non-Preferred Drugs - Check box below that applies:**

| Non-Preferred with Age Restrictions | |
|---|---|
| ❑ **Invokamet®** (canagliflozin/metformin HC1) | ❑ **Invokamet XR®** (canagliflozin/metformin HC1 extended-release) (Age) |
| ❑ **Xigduo® XR** (dapagliflozin/metformin HC1 extended-release) (Age) | ❑ **Steglatro®** (ertugliflozin) |
| ❑ **Segluromet®** (ertugliflozin/metformin) | ❑ **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

| Preferred Drugs (Age Restrictions): Patient must be ≥ 18 years of age to qualify. | | |
|---|---|---|
| ❑ Farxiga® (dapagliflozin) | ❑ Invokana® (canagliflozin) | ❑ Jardiance® (empagliflozin) |
| ❑ Synjardy® (empagliflozin/metformin HC1) | ❑ Glyxambi® (empagliflozin/linagliptin) | |

**(continued on next page; signature page MUST be attached with this request.)**

**(Signature page <u>MUST</u> be attached to this request.)**

***Use of samples to initiate therapy <u>does not</u> 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 #:** ______________________________________________

**REVISED/UPDATED:** ~~6/30/2017; 8/29/2017; 7/3/2018;~~ **8/29/2018**