OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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:

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)	

****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 #: ____

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