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

DRUGS: select applicable box below:	
Preferred (Age Restrictions)	**Non-Preferred (Age Restrictions)**
❑ **Farxiga**® (dapagliflozin)	❑ **Glyxambi**® (empagliflozin/linagliptin)
❑ **Invokana**® (canagliflozin)	❑ **Invokamet**® (canagliflozin/metformin HC1)
	❑ **Invokamet XR**® (canagliflozin/metformin HC1 extended-release)
	❑ **Jardiance**® (empagliflozin)
	❑ **Synjardy**® (empagliflozin/metformin HC1))
	❑ **Synjardy**® **XR** (empagliflozin/metformin HC1 extended-release)
	❑ **Xigduo**® **XR** (dapagliflozin/metformin HC1 extended-release)

DRUG INFORMATION: Complete information below. If incomplete, 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 Preferred and Non-Preferred SGLT2 Drugs. Age Restriction Applies.

❑ Patient diagnosed with Type 2 diabetes and has been compliant with and has not achieved adequate glycemic control ***with metformin;***

OR

❑ Patient is intolerant to metformin

AND

❑ Patient is ≥ 18 years old

****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**