OPTIMA HEALTH PLAN

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 ***(select one below)*****:** ***SGLT2 Drugs*** ***(COMMERCIAL ONLY)***

❑ **Farxiga**® (dapagliflozin)	❑ **Xigduo**® **XR** (dapagliflozin/metformin ER)
❑ **Glyxambi**® (empagliflozin/linagliptin)	

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*****:** _____

CLINICAL CRITERIA**:** ***Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.***

- ❑ Patient has tried and failed at least ***30 days*** of therapy with the following:
  - ❑ Invokana®

    OR
  - ❑ Invokamet® or Invokamet® XR

    AND
  - ❑ Jardiance®

    OR
  - ❑ Synjardy® or Synjardy® XR

*****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 #: _____

***Approved by the Pharmacy and Therapeutics Committee**: 5/16/2013
REVISED/UPDATED: 9/30/2013; 4/7/2014; 8/6/2014; 9/26/2014; 10/8/2014; 10/16/14; **10/30**/2014; 1/15/15; 10/15/2015; 10/23/2015; 12/22/20215; 12/19/2016; 3/6/2017; 3/27/17; **3/28/2017;** 5/4/2017; **8/17/2017**