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*** ***MEDICAID ONLY***

❑ **Invokana**® (canagliflozin)	❑ **Farxiga**® (dapagliflozin)	❑ **Jardiance**® (empagliflozin)
❑ **Invokamet**®/**Invokamet**® **XR** (canagliflozin/metformin/metformin ER)	❑ **Xigduo**® **XR** (dapagliflozin/metformin ER)	❑ **Glyxambi**® (empagliflozin/linagliptin)
❑ **Synjardy**®/**Synjardy**® **XR** (empagliflozin/ metformin)		

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*****:** _____

- ***DO NOT INITIATE or CONTINUE therapy for:***
  - Invokana® or Invokamet/XR® if eGFR is ***below*** 45ml/min/1.73m^2
  - Farxiga™ or Xigduo™ if eGFR is ***below*** 60ml/min/1.73m^2
  - Jardiance®, Glyxambi® or Synjardy/XR® if eGFR is ***below*** 45ml/min/1.73m^2
- These medications are ***NOT*** indicated for weight loss or the treatment of hypertension.

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 metformin***

AND

❑ ***Patient has tried and failed at least 30 days of therapy with TWO (2) of the following: *NOTE: A DPP-IV inhibitor MUST be tried for Glyxambi approval****

- ❑ sulfonylurea
- ❑ Dipeptidyl Peptidase (DPP)-IV inhibitor
- ❑ Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist

❑ **Patient's estimated Glomerular Filtration Rate (eGFR)** _____ **Date collected:** _____

(NOTE: eGFR must be current, collected within the past 12 months)

*****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**: 11/17/2016
REVISED/UPDATED: ~~3/28/2017; 5/4/2017; 5/17/2017;~~ **8/17/2017'**