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/FAMIS)***

PREFERRED BRANDS		
❑ **Invokana**® (canagliflozin)	❑ **Farxiga**® (dapagliflozin)	
NON-PREFERRED BRANDS		
❑ **Glyxambi**® (empagliflozin/linagliptin)	❑ **Invokamet**®**/Invokamet**® **XR** (canagliflozin/metformin/metformin ER)	❑ **Jardiance**® (empagliflozin)
❑ **Qtern**® (dapagliflozin/ertugliflozin)	❑ **Steglatro**® (ertugliflozin)	❑ **Steglujan**® (ertugliflozin/sitagliptin)
❑ **Segluromet**® (ertugliflozin/metformin)	❑ **Synjardy**®**/Synjardy**® **XR** (empagliflozin/ metformin)	❑ **Xigduo**® **XR** (dapagliflozin/metformin ER)

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*****:** _____

Initial Authorization – 6 months; Reauthorization – 1 year

Age Limit - ≥ 18 years of age

CLINICAL CRITERIA**:** ***Check box below to qualify or authorization process will be delayed.***

❑ ***Patient has trial and failure or intolerance at least 30 days of therapy with metformin***

****eGFR criteria will go away along with the weight loss/hypertension disclaimer**

*****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;~~ **6/18/2018**;