



Please note: All information below is required to process this request.  
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



## Farxiga<sup>®</sup>, Glyxambi<sup>®</sup>, Xigduo<sup>®</sup> XR Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information (required)   |        |      | Provider Information (required) |        |              |
|---|--------|------|---------------------------------|--------|--------------|
| Member Name:  |        |      | Provider Name:                  |        |              |
| Insurance ID#:  |        |      | NPI#:                           |        | Specialty:   |
| Date of Birth:  |        |      | Office Phone:                   |        |              |
| Street Address:   |        |      | Office Fax:                     |        |              |
| City:   | State: | Zip: | Office Street Address:          |        |              |
| Phone:  |        |      | City:                           | State: | Zip:         |
| Medication Information (required)   |        |      |                                 |        |              |
| Medication Name:  |        |      | Strength:                       |        | Dosage Form: |
| <input type="checkbox"/> Check if requesting <b>brand</b>   |        |      | Directions for Use:             |        |              |
| <input type="checkbox"/> Check if request is for <b>continuation of therapy</b>   |        |      |                                 |        |              |
| Clinical Information (required)   |        |      |                                 |        |              |
| <b>Select if the patient has tried and failed at least 30 days of therapy with the following:</b>   |        |      |                                 |        |              |
| <input type="checkbox"/> Invokamet<br><input type="checkbox"/> Invokamet XR<br><input type="checkbox"/> Invokana<br><input type="checkbox"/> Jardiance<br><input type="checkbox"/> Synjardy<br><input type="checkbox"/> Synjardy XR |        |      |                                 |        |              |
| <b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b><br><b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>                            |        |      |                                 |        |              |
| Prescriber Signature: _____   |        |      | Date: _____                     |        |              |

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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