CAREFIRST F3
Antidiabetic Agents Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Antidiabetic Agents Step Therapy .

Patient Information

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (specify drug)

_____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Does the patient have a diagnosis of type 2 diabetes mellitus?	**Y** ☐	**N** ☐
2.	Has the patient been receiving a stable maintenance dose of the requested drug for at least 3 months?	**Y** ☐	**N** ☐
3.	Has the patient demonstrated a reduction in A1C since starting this therapy?	**Y** ☐	**N** ☐
4.	Is this request for SymlinPen (pramlintide acetate)?	**Y** ☐	**N** ☐
5.	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to metformin?	**Y** ☐	**N** ☐
6.	Does the patient require combination therapy AND have an A1C of 7.5 percent or greater?	**Y** ☐	**N** ☐
7.	Does the patient have any of the following?		

- Established cardiovascular disease (If checked, go to 8) ☐
- Diabetic nephropathy with albuminuria greater than 300 mg per day (If checked, go to 9) ☐
- Multiple cardiovascular risk factors (If checked, go to 10) ☐
- Heart failure (If checked, go to 11) ☐
- Chronic kidney disease at risk of progression (If checked, go to 12) ☐
- None of the above (if checked, no further questions) ☐

8.	Is this request for Farxiga (dapagliflozin), Invokana (canagliflozin), or Jardiance (empagliflozin)?	**Y** ☐	**N** ☐

9.	Is this request for Invokana (canagliflozin)?	**Y** ☐	**N** ☐
10.	Is this request for Farxiga (dapagliflozin)?	**Y** ☐	**N** ☐
11.	Is this request for Farxiga (dapagliflozin) or Jardiance (empagliflozin)?	**Y** ☐	**N** ☐
12.	Is this request for Farxiga (dapagliflozin) or Jardiance (empagliflozin)?	**Y** ☐	**N** ☐
13.	Is the request for any of the following?		
	SymlinPen (If checked, go to 14)	☐	
	Farxiga (If checked, go to 18)	☐	
	Jardiance (If checked, go to 20)	☐	
	None of the above (if checked, no further questions)	☐	
14.	Does the patient have a diagnosis of type 1 diabetes mellitus?	**Y** ☐	**N** ☐
15.	Has the patient been receiving a stable maintenance dose of the requested drug for at least 3 months?	**Y** ☐	**N** ☐
16.	Has the patient demonstrated a reduction in A1C since starting this therapy?	**Y** ☐	**N** ☐
17.	Has the patient failed to achieve desired glucose control despite receiving optimal insulin therapy, including mealtime insulin?	**Y** ☐	**N** ☐
18.	Does the patient have a diagnosis of heart failure?	**Y** ☐	**N** ☐
19.	Does the patient have chronic kidney disease at risk of progression?	**Y** ☐	**N** ☐
20.	Does the patient have a diagnosis of heart failure?	**Y** ☐	**N** ☐
21.	Does the patient have chronic kidney disease at risk of progression?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date