

## 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:    -    -    [illegible]

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 | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Has the patient been receiving a stable maintenance dose of the requested drug for at least 3 months?                                | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Has the patient demonstrated a reduction in A1C since starting this therapy?                                                         | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Is this request for SymlinPen (pramlintide acetate)?                                                                                 | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to metformin? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Does the patient require combination therapy AND have an A1C of 7.5 percent or greater?                                              | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | Does the patient have any of the following?                                                                                          |   |                          |   |                          |
|    | Established cardiovascular disease (If checked, go to 8)                                                                             |   | <input type="checkbox"/> |   |                          |
|    | Diabetic nephropathy with albuminuria greater than 300 mg per day (If checked, go to 9)                                              |   | <input type="checkbox"/> |   |                          |
|    | Multiple cardiovascular risk factors (If checked, go to 10)                                                                          |   | <input type="checkbox"/> |   |                          |
|    | Heart failure (If checked, go to 11)                                                                                                 |   | <input type="checkbox"/> |   |                          |
|    | Chronic kidney disease at risk of progression (If checked, go to 12)                                                                 |   | <input type="checkbox"/> |   |                          |
|    | None of the above (if checked, no further questions)                                                                                 |   | <input type="checkbox"/> |   |                          |
| 8. | Is this request for Farxiga (dapagliflozin), Invokana (canagliflozin), or Jardiance (empagliflozin)?                                 | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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

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.

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**Prescriber (Or Authorized) Signature and Date**

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