BlueCross BlueShield Federal Employee Program.

SGLT2 INHIBITORS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

For Standard Option patients Farxiga, Glyxambi, Jardiance, Qtern, Synjardy/Synjardy XR, and Xigduo XR are preferred products. Standard Option patients who switch to a preferred product can receive up to 2 fills without a copay in the benefit year.

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Invokamet 50/500mg**	❑**Invokamet XR 50/500mg**	❑**Brenzavvy**	❑**Steglatro**
❑**Invokamet 50/1000mg**	❑**Invokamet XR 50/1000mg**	❑**Invokana 100mg**	❑**Steglujan**
❑**Invokamet 150/500mg**	❑**Invokamet XR 150/500mg**	❑**Invokana 300mg**	
❑**Invokamet 150/1000mg**	❑**Invokamet XR 150/1000mg**	❑**Segluromet**	

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. **Standard Option Patient**: Would you like to participate in this program and switch the patient to a preferred medication: Farxiga, Glyxambi, Jardiance, Qtern, Synjardy, Synjardy XR, or Xigduo XR? ***Please select answer below:***

   ❑**Yes** ***(select medication)***: ❑Farxiga ❑Glyxambi ❑Jardiance ❑Qtern ❑Synjardy ❑Synjardy XR ❑Xigduo XR

   a. Does the patient have a contraindication to or have they had either an inadequate response or intolerance to metformin? ❑Yes ❑No

   ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** of the following preferred medications: Farxiga, Glyxambi, Jardiance, Qtern, Synjardy, Synjardy XR, and/or Xigduo XR?

   ❑**Tried ONE Preferred** ***(specify drug and result)***: _____

   ❑**Tried TWO Preferred** ***(specify drugs and results)***: _____

   _____

   ❑**No**: Is there a clinical reason for not trying a preferred medication? ❑Yes***** ❑No

   ****If YES***, please specify: _____

2. Is this medication being used *exclusively* for weight loss? ❑Yes ❑No

3. Does the patient have a diagnosis of type 2 diabetes mellitus (DM)? ❑Yes ❑No

4. **Invokana 100mg Request**: Does the patient have a urinary albumin (microalbumin) level greater than 300mg per day? ❑Yes ❑No

5. What is the patient's eGFR? _____ mL/min/1.73m^2

6. Is the patient being treated for diabetic ketoacidosis (DKA), whose symptoms include nausea and/or vomiting, difficulty breathing, fruity odor on breath, and confusion which can require immediate medical attention? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

7. Will this medication be used in combination with other ***SGLT2 inhibitors? ❑Yes* ❑No

If YES, please specify: _____

SGLT2 Inhibitors: Brenzavvy, Farxiga, Glyxambi, Inpefa, Invokamet/Invokamet XR, Invokana, Jardiance, Qtern, Segluromet, Steglatro, Steglujan, Synjardy/Synjardy XR, Trijardy XR, Xigduo XR

8. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to metformin? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an alpha-glucosidase inhibitor, dipeptidyl peptidase 4 inhibitors (DPP-4), glucagon-like peptide-1 receptor agonists (GLP-1), or thiazolidinedione therapy? ❑Yes ❑No

c. Does the patient have a HgbA1C (hemoglobin A1C) greater than 7.0%? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times***.