



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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			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:**

- |   |  |   |                                    |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Invokamet 50/500mg   | <input type="checkbox"/> Invokamet XR 50/500mg   | <input type="checkbox"/> Brenzavvy      | <input type="checkbox"/> Steglatro |
| <input type="checkbox"/> Invokamet 50/1000mg  | <input type="checkbox"/> Invokamet XR 50/1000mg  | <input type="checkbox"/> Invokana 100mg | <input type="checkbox"/> Steglujan |
| <input type="checkbox"/> Invokamet 150/500mg  | <input type="checkbox"/> Invokamet XR 150/500mg  | <input type="checkbox"/> Invokana 300mg |                                    |
| <input type="checkbox"/> Invokamet 150/1000mg | <input type="checkbox"/> Invokamet XR 150/1000mg | <input type="checkbox"/> Segluromet     |                                    |

\*\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefitIs 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<sup>2</sup>

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****PAGE 1 of 2**



**BlueCross  
BlueShield**

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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:

<b>Electronically Online</b> (ePA) <b>Results in 2-3 minutes</b> <b>FASTEST AND EASIEST</b>	Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> 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 <b>Caremark.com/ePA</b> .
<b>Phone</b> (4-5 minutes for response)	The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> 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.
<b>Fax</b> (3-5 days for response)	Fax the attached form to <b>(877)-378-4727</b> . 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. <b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b>

**faster...**  
**easier...**  
**better...**

Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA. Sign up today!

**CVS/caremark** 