BlueCross BlueShield Federal Employee Program

TRIJARDY XR
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder 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					

Trijardy XR

(empagliflozin, linagliptin, and metformin)

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

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

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

1. What is the patient's diagnosis?
   - ❑Type 1 diabetes mellitus
   - ❑Type 2 diabetes mellitus
   - ❑Prevention of diabetes (pre-diabetic)
   - ❑Other diagnosis ***(please specify)*:** _____

2. Is Trijardy XR being used *exclusively* for weight loss? ❑Yes ❑No

3. Does the patient have an eGFR greater than or equal to 45 mL/min/1.73^2? ❑Yes ❑No

4. 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

5. Will the patient be using another SGLT2 medication in addition to Trijardy XR? ❑Yes* ❑No
   If YES, please specify medication: _____

6. Has the patient been on Trijardy XR 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 a contraindication to or have they had either an inadequate response or intolerance to metformin? ❑Yes ❑No
   - b. Does the patient have a contraindication to or have they had either an inadequate response or intolerance 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 contraindication to or have they had either an inadequate response or intolerance to **TWO** SGLT2 inhibitors? ❑Yes ❑No

     SGLT2 Inhibitors include: Farxiga, Glyxambi, Invokamet/Invokamet XR, Invokana, Jardiance, Qtern, Segluromet, Steglatro, Steglujan, Synjardy/Synjardy XR, and Xigduo XR
   - d. What is the patient's HgbA1C (hemoglobin A1C)? _____ %

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   - a. Has the patient's condition improved or stabilized on the Trijardy XR 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.***