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

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.
SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

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**	❑**dapagliflozin**
❑**Invokamet 150/1000mg**	❑**Invokamet XR 150/1000mg**	❑**Segluromet**	❑**dapagliflozin/metformin**

****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

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

1. **Standard/Basic Option Patient**: Has the patient tried and failed Farxiga, Glyxambi, Jardiance, Qtern, Synjardy, Synjardy XR, or Xigduo XR? ***Select answer below:***

   ❑**YES - Please specify the medications and medical record page number(s):**

   PAGE(s)_____ of _____ Medications: _____

   ❑**NO**, the patient has not tried and failed any of these medications.

2. **Standard/Basic Option Patient**: Would you like to switch to a preferred medication? The preferred medications are Farxiga, Glyxambi, Jardiance, Qtern, Synjardy, Synjardy XR, and Xigduo XR. ***Please select answer below:***

   ❑**YES - Please select the medication**: ❑Farxiga ❑Glyxambi ❑Jardiance ❑Qtern ❑Synjardy ❑Synjardy XR ❑Xigduo XR

   ❑**NO**, do not switch

   ❑**NO**, do not switch however the patient has a medical exception. **DOCUMENTATION IS REQUIRED**: Please specify the medical record page number(s). **PAGE(s)_____ of _____**

   ❑**NO**, do not switch however I would like to speak with a medical director to discuss the case. Please specify the preferred date and time to contact, including the time zone, and the phone number: _____

   _____

3. **Blue Focus Patient**: This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed.

   ❑Please specify the formulary alternative medication(s) and medical record page number(s).

   PAGE(s)_____ of _____ Medications: _____

   ❑The patient has not tried and failed any formulary alternatives.

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 – PHYSICIAN COMPLETES

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

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

4. **Blue Focus Patient**: Would you like to switch to a preferred medication? The preferred medications are Farxiga, Glyxambi, Jardiance, Qtern, Synjardy, Synjardy XR, and Xigduo XR. ***Please select answer below:***
   ❑**YES - Please select the medication**: ❑Farxiga ❑Glyxambi ❑Jardiance ❑Qtern ❑Synjardy ❑Synjardy XR ❑Xigduo XR
   ❑**NO**, do not switch
5. Is this medication being used *exclusively* for weight loss? ❑Yes ❑No
6. Does the patient have a diagnosis of type 2 diabetes mellitus (DM)? ❑Yes* ❑No
   ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
7. 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
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
      ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
   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
      ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
   c. Does the patient have a HgbA1C (hemoglobin A1C) greater than 7.0%? ❑Yes* ❑No
      ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
   ❑**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
      ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
9. **Invokana 100mg Request**: Does the patient have a urinary albumin (microalbumin) level greater than 300 milligrams per day? ❑Yes* ❑No
   ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
10. Does the patient have an eGFR greater than or equal to 30 milliliters per minute per 1.73 square meter (mL/min/1.73m^2)?
    Please select answer below:
    ❑eGFR less than 30 mL/min/1.73m^2
    ❑eGFR between 30 mL/min/1.73m^2 and 44 mL/min/1.73m^2
    Please specify the medical record page number(s). PAGE(s)_____ of _____
    ❑eGFR 45 mL/min/1.73m^2 or greater
    Please specify the medical record page number(s). PAGE(s)_____ of _____