Antidiabetic Noninsulin Agent
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for preferred antidiabetic, noninsulin agents subject to clinical criteria. Payment will be considered under the following conditions:

1. Patient has an FDA approved or compendia indicated diagnosis
2. Patient meets the FDA approved or compendia indicated age
3. For the treatment of Type 2 Diabetes Mellitus, the patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose.
4. Requests for non-preferred anti-diabetic, non-insulin agents subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor at maximally tolerated doses.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).

Preferred DPP-4 inhibitors and combos

☐ Janumet ☐ Jentadueto
☐ Janumet XR ☐ Tradienta
☐ Januvia

Nonpreferred DPP-4 inhibitors and combinations

☐ Alogliptin ☐ Glyxambi ☐ Kombiglyze XR ☐ Oseni
☐ Alogliptin-Metaformin ☐ Jentadueto XR ☐ Nesina
☐ Alogliptin-Pioglitazone ☐ Kanzano ☐ Onglyza

Preferred incretin mimetics

☐ Byetta ☐ Ozempic
☐ Bydureon ☐ Victoza

Nonpreferred incretin mimetics

☐ Adlyxin ☐ Rybelsus
☐ Bydureon BCise ☐ Trulicity

Preferred SGLT2 inhibitors and combinations

☐ Jardiance ☐ Synjardy
☐ Farxiga

Nonpreferred SGLT2 inhibitors and combinations

☐ Invokamet ☐ Otern ☐ Steglujan
☐ Invokamet XR ☐ Segluromet ☐ Xigduo XR
☐ Invokana ☐ Steglatro ☐ Synjardy XR

Metformin trial

Trial start date: _____ Trial end date: _____ Trial dose: _____
Reason for failure: _____
Medical or contraindication reason to override trial requirements: _____
_____

Most recent HgbA1C level: _____ Date this level was obtained: _____

Requests for nonpreferred drugs

Preferred DPP-4 trial: drug name/dose: _____
Trial start date: _____ Trial end date: _____
Reason for failure: _____
Preferred incretin mimetic trial: drug name/dose: _____
Trial start date: _____ Trial end date: _____
Reason for failure: _____
Preferred SGLT2 trial: drug name/dose: _____
Trial start date: _____ Trial end date: _____
Reason for failure: _____
Reason for use of nonpreferred drug requiring prior approval: _____
_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.