

SGLT-2 Inhibitors- Arizona

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**. This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Address: City: State: ZIP Code: Phone: DOB: Allergies: Primary Insurance Information (if any): Is the requested medication: New or Continuation of Therapy? If continuation, list start date: Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: Section B - Provider Information First Name: Last Name: M.D./D.O. Address: City: State: ZIP code: Phone: Fax: NPI #: Specialty: Office Contact Name / Fax attention to: Section C - Medical Information Medication: Strength: Directions for use: Quantity: Diagnosis (Please be specific & provide as much information as possible): ICD-10 CODE: Is this member pregnant? Yes No If yes, what is this member's due date?	Section A - Member Infor	mation								
State: ZIP Code:	First Name:		Last Name:	Last Name:				Member ID:		
Phone: DOB: Allergies:	Address:									
Primary Insurance Information (if any): Is the requested medication:	City:	ZIP G	ZIP Code:							
Section B - Provider Information First Name: Address: City: State: ZIP code: Phone: Office Contact Name / Fax attention to: Section C - Medical Information Medication: Directions for use: Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant? □ Yes □ No If yes, what is this member's due date? Section D - Previous Medication Trials Medication Name Strongth Page of Thoragy Reason for failure /	Phone:		DOB:			Allergi	es:			
Is this patient currently hospitalized?	Primary Insurance Information	(if any):								
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Section D – Previous Medication Trials Medication Name Strength Directions Dates of Thorany Reason for failure /		.,		,						
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	Section D – Previous Med	ication Trials					Peace	n for failure /		
	Medication Name	Strength	Dire	ctions	Dates of Thera	ру				
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		+								
Section E – Additional information and Explanation of why preferred medications would not meet the patient's ne	Section E – Additional inf	ormation and Ex	planation	of why pref	erred medications v	vould n	ot meet th	ne patient's need		
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives										



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Member First name:		Member Last name:		Member DOB:					
	Clinical and Drug Specific Information								
		ALL REQUESTS	S						
□ Yes □ No	Does the patient have a	diagnosis of type 2 diabete	es mellitus?						
□ Yes □ No	Does the patient have a history of failure to metformin at a minimum dose of 1500mg daily for 90 days? (If yes, complete Section D above)								
□ Yes □ No	Does the patient have a If yes, list reason:	contraindication or intoler	ance to metf	formin?					
□ Yes □ No		a history of failure, intolerar lies and complete Section Da		aindication to the following?					
Provider Si	gnature:			Date:					

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