

Januvia / Janumet / Janumet XR

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION

Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW or a CONTINUATION of THERAPY ? If so, start date: _____

Is this patient currently hospitalized? Yes No

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: Zip:
Phone: Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:		

SECTION C - MEDICATION INFORMATION

Medication:	Strength:
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible):	ICD 9 Code:

Preferred DPP4 Alternatives (with step therapy): Onglyza, Kombiglyze, Tradjenta, Jentaduetto

Has the patient tried and failed any of the following? (check any that apply)

Metformin/metformin ER (eg, Glucophage, Glucophage XR)

Sulfonylurea [eg, Amaryl (glimepiride), Diabeta (glyburide), Glucotrol (glipizide)]

Thiazolidinedione (TZD) [eg, Actos (pioglitazone), Avandia (rosiglitazone)]

Insulin [eg, Humalog, Humulin, Novolin, Novolog, Lantus]

Byetta (exenatide)

For any that are checked please provide dates of therapy and reason for discontinuation:

Which of the following preferred DPP4 inhibitors has the patient tried previously? ?

Onglyza Tradjenta

Kombiglyze Jentaduetto

For any that are checked please provide dates of therapy and reason for discontinuation:

Physician Signature: _____ **Date:** _____