

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.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
 Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of type 2 diabetes mellitus?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure to metformin at a minimum dose of 1500mg daily for 90 days? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a contraindication or intolerance to metformin? <i>If yes, list reason:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure for 90 days, intolerance, or contraindication to the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Steglatro (ertugliflozin) <input type="checkbox"/> Segluromet (ertugliflozin/metformin)

FARXIGA / INVOKANA / JARDIANCE

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented history of heart failure?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented history of chronic kidney disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented history of atherosclerotic cardiovascular disease defined as having one of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Coronary heart disease with or without revascularization <input type="checkbox"/> History of an acute coronary syndrome or myocardial infarction <input type="checkbox"/> Other arterial revascularization <input type="checkbox"/> Peripheral artery disease assumed to be atherosclerotic in origin <input type="checkbox"/> Stable or unstable angina <input type="checkbox"/> Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>For Farxiga request only:</u> Does the patient have two of the following risk factors for developing cardiovascular disease? <i>(If yes, check which applies)</i> <input type="checkbox"/> Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication <input type="checkbox"/> Cigarette smoker or stopped smoking within the past 3 months <input type="checkbox"/> Creatinine clearance greater than 30 and less than 60 mL/min <input type="checkbox"/> HDL-C (high-density lipoprotein cholesterol) ≤ 40 mg/dL for men or ≤ 50 mg/dL for women <input type="checkbox"/> High-sensitivity C-reactive protein greater than 3.0 mg/L <input type="checkbox"/> Hypertension (pretreatment blood pressure greater than or equal to 140 mm/Hg systolic or greater than or equal to 90 mm/Hg diastolic) <input type="checkbox"/> Men ≥ 55 years and women ≥ 65 years of age <input type="checkbox"/> Micro- or macro-albuminuria <input type="checkbox"/> Retinopathy
<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>For Invokana request only:</u> Does the patient have a documented history of diabetic nephropathy with albuminuria greater than 300 mg/day?

Provider Signature: _____ **Date:** _____

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