UnitedHealthcare Community Plan

SGLT-2 Inhibitors – New York EPP

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.

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: □ 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 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

UnitedHealthcare Community Plan

SGLT-2 Inhibitors – New York EPP
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a diagnosis of type 2 diabetes mellitus?**
□ Yes □ No	**Does the patient have a history of failure, intolerance, or contraindication to metformin at a minimum dose of 1500mg daily for 90 days?** *(If yes, complete Section D above)*
FARXIGA / SEGLUROMET / STEGLATRO / XIGDUO XR	
□ Yes □ No	**Does the patient have a history of failure, intolerance, or contraindication to any of the following?** *(If yes, check which applies and complete Section D above)* □ Invokana (canagliflozin) □ Invokamet (canagliflozin/metformin) □ Invokamet XR (canagliflozin/metformin) □ Jardiance (empagliflozin) □ Synjardy (empagliflozin/metformin) □ Synjardy XR (empagliflozin/metformin)

Provider Signature: ____ **Date:** ___________________

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.