UnitedHealthcare Community Plan

Hypoglycemics, SGLT2 Inhibitor - Pennsylvania
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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

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: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
□ Yes □ No	**Does the patient have type 2 diabetes mellitus?**
□ Yes □ No	**Does the patient have a documented history of any of the following?** *(If yes, check which applies)* □ Failure to achieve glycemic control as evidenced by the patient's HbA1c (hemoglobin A1c) values using maximum tolerated doses of metformin □ A contraindication or intolerance to metformin □ Requires initial dual therapy with metformin based on HbA1c as defined by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology □ If the requested medication has proven cardiovascular disease (CVD), heart failure (HF), or chronic kidney disease (CKD) benefit, the patient has CVD (or two risk factors for CVD as identified by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology), HF, or CKD
□ Yes □ No	**Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred SGLT2 (sodium/glucose cotransporter 2) inhibitors?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*

Provider Signature: _____ Date: _____