

Hypoglycemics, SGLT2 Inhibitor - Pennsylvania Prior Authorization Request Form

Please complete this <u>entire</u> 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 Nam	Provider Name:					
Member ID:			\$	Specialty:				
Date Of Birth:		Office Phone:	Office Phone:					
		Office Fax:	Office Fax:					
State:	ZIP Code:	Office Street A	Address:					
Allergi	es:	City:	State:	ZIP Code:				
Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date:								
-		=	_	_				
nt? □ Yes □	No If yes, what	is this member's	due date?					
	Medica	ation Information						
			O	Quantity:				
: □ Self-Adm	inistered ☐ Phys	sician's Office 🔲 (Other:					
	Clini	cal Information	1					
iagnosis for	the medication be	eing requested? _						
								
Previous Medication Trials / Contraindications								
			my <u>ALL</u> medication(s	s/strengtns triea, airections,	,			
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								
radicolal information that may be important for this review								
i	State: Allergination: New hospitalized the Self-Administratory or laboratory or labo	State: ZIP Code: Allergies: ation: New or Continuation hospitalized? Yes No hospitalized? Yes, what Medical Self-Administered Physical Self-Administered Physical Cliniting daboratory or test results related Previous Medication refer to the patient's PDL at www. the patient have a history of fails or discontinuation of each medication the patient have a contraindication the patient have a contraindication	Provider Nam NPI #: Office Phone: Office Fax: State: ZIP Code: Office Street // Allergies: City: ation: New or Continuation of Therapy? If // hospitalized? Yes No If recently dischant? Yes No If yes, what is this member's Medication Information Clinical Information agnosis for the medication being requested? Alaboratory or test results related to the patient's diagnosis for the patient's PDL at www.uhcprovider.com the patient have a history of failure to? (Please spector discontinuation of each medication) the patient have a contraindication or intolerance to to or specific issues resulting in intolerance to each medication.	Provider Name: NPI #: Office Phone: Office Fax: Office Fax: Office Street Address: City: State: Allergies: City: State: State: State: Allergies: Office Street Address: State: State:	Provider Name: NPI #: Specialty: Office Phone: Office Phone: Office Phone: Office Fax: State: ZIP Code: Office Street Address: ZIP Code: ation: New or Continuation of Therapy? If continuation, list start date: It hospitalized? Yes No If recently discharged, list discharge date: It? Yes No If yes, what is this member's due date? Medication Information Strength: Quantity: Quantity: Quantity: Self-Administered Physician's Office Other: Quantity: Clinical Information			



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Member First	name:	Member Last name:	Member DOB:
		Clinical and Drug Specific Inforn	nation
□ Yes □ No	Does the patient have ty	pe 2 diabetes mellitus?	
□ Yes □ No	 □ Failure to achieve glyce maximum tolerated dos □ A contraindication or in □ Requires initial dual the Association or the Ame Endocrinology □ If the requested medica disease (CKD) benefit, 	tolerance to metformin erapy with metformin based on HbA1c as a erican Association of Clinical Endocrinolog ation has proven cardiovascular disease (the patient has CVD (or two risk factors for the American Association of Clinical End	defined by the American Diabetes gists and American College of CVD), heart failure (HF), or chronic kidney or CVD as identified by the American
□ Yes □ No	SGLT2 (sodium/glucose	history of therapeutic failure, contraind cotransporter 2) inhibitors? s Medication Trials/Contraindications" sed	ction on first page)

Provider Signature:	Date:	

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