

## SGLT-2 Inhibitors – Rhode Island 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: <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](http://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	<b>Does the patient have a diagnosis of type 2 diabetes mellitus?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, intolerance, or contraindication to at least <u>two</u> generic agents, one of which must be metformin at a minimum dose of 1500 mg daily for 90 days?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure for 90 days, intolerance, or contraindication to the following? (If yes, check which applies and complete Section D above)</b> <input type="checkbox"/> Steglatro (ertugliflozin) <input type="checkbox"/> Segluromet (ertugliflozin/metformin)

**INVOKANA / INVOKAMET / INVOKAMET XR / JARDIANCE**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a documented history of heart failure?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a documented history of chronic kidney disease?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a documented history of atherosclerotic cardiovascular disease defined as having one of the following? (If yes, check which applies)</b> <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	<b><u>For Invokana request only:</u> Does the patient have a documented history of diabetic nephropathy with albuminuria greater than 300 mg/day?</b>

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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