UnitedHealthcare Community Plan

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: □ 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

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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 at least <u>two</u> generic agents, one of which must be metformin at a minimum dose of 1500 mg daily for 90 days?**
□ Yes □ No	**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)* □ Steglatro (ertugliflozin) □ Segluromet (ertugliflozin/metformin)
INVOKANA / INVOKAMET / INVOKAMET XR / JARDIANCE	
□ Yes □ No	**Does the patient have a documented history of heart failure?**
□ Yes □ No	**Does the patient have a documented history of chronic kidney disease?**
□ Yes □ No	**Does the patient have a documented history of atherosclerotic cardiovascular disease defined as having one of the following?** *(If yes, check which applies)* □ Coronary heart disease with or without revascularization □ History of an acute coronary syndrome or myocardial infarction □ Other arterial revascularization □ Peripheral artery disease assumed to be atherosclerotic in origin □ Stable or unstable angina □ Stroke
□ Yes □ 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: _____