Pharmacy Prior Authorization

MERCY CARE (MEDICAID)

SGLT2 Inhibitors (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**.
When conditions are met, we will authorize the coverage of SGLT2 Inhibitors (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Specify drug ____________________

Quantity ________ Frequency ____________ Strength ________

Route of Administration ________ Expected Length of therapy ____________

Patient Information

Patient Name: ____________________

Patient ID: ____________________

Patient Group No.: ____________________

Patient DOB: ____________________

Patient Phone: ____________________

Prescribing Physician

Physician Name: ____________________

Specialty: ____________________ NPI Number: ____________________

Physician Fax: ____________________ Physician Phone: ____________________

Physician Address: ____________________ City, State, Zip: ____________________

Diagnosis:____________________ **ICD Code:**____________________

Please circle the appropriate answer for each question.

1. Is the patient CURRENTLY taking metformin? Y N

   [If yes, then skip to question 4.]

2. Did the patient have a previous inadequate response or adverse effect to metformin? Y N

   Please explain reason for metformin failure:

   ____

   [If yes, then skip to question 4.]

3. Does the patient have any of the following contraindications to metformin: A) Renal dysfunction (serum creatinine greater than 1.4mg per dL for females or greater than 1.5mg per dL for males), B) Y N

Metabolic acidosis, C) Diabetic ketoacidosis?

Please list contraindication(s):

____

[If no, then no further questions]

4. Is the patient 18 years of age or older? Y N

[If no, then no further questions.]

5. Is this request for a formulary preferred agent? (refer to formulary for a list of preferred agents) Y N

[If yes, then no further questions.]

6. Has the patient had a trial and failure of a formulary preferred SGLT2 Inhibitor? (refer to formulary for a list of preferred agents) Y N

Please list medications tried and reason for medication failure:

____

Comments:

____

____

I affirm that the information given on this form is true and accurate as of this date.

____

Prescriber (Or Authorized) Signature **Date**