Farxiga (dapagliflozin)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Type II diabetes for blood glucose control ☐ Heart Failure ☐ Type II diabetes with established cardiovascular disease and/or with additional cardiovascular risk ☐ Chronic kidney disease ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For patient with Type II Diabetes only, answer the following:

Is the patient's estimated glomerular filtration rate (GFR) below 60 mL/min/1.73 m2?* ☐ **Yes** ☐ **No**
***Please provide documentation.**

Is the patient on dialysis? ☐ **Yes** ☐ **No**

Is the patient already taking the requested medication? ☐ **Yes** ☐ **No**

Was the patient's hemoglobin A1C (HbA1c) 7.0% or greater prior to therapy (HbA1c must be taken within the past 6 months if the patient has not been on this treatment previously)?* ☐ **Yes** ☐ **No**
***Copy of HbA1c level required.**

Is the patient currently on metformin?* ☐ **Yes** ☐ **No**

Does the patient had an inadequate response or intolerance to metform? ☐ **Yes** ☐ **No**
Please provide documentation

Does the patient have at least one of the following contraindication to metformin? ☐ **Yes** ☐ **No (Please Check one)**
☐ **Estimated glomerular filtration rate (GFR) less than or equal to 30 mL/min/1.73 m2**
☐ **Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy**

For patient with Type II diabetes with established cardiovascular disease and/or risks, answer the following:

Is the patient 40 years of age or older? ☐ **Yes** ☐ **No**
Does patient have Type II diabetes? ☐ **Yes** ☐ **No**

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Is patient's most recent HgbA1c level in the past 6months AT LEAST 6.5% and is LESS THAN 12.0%, prior to therapy (HbA1c must be taken within the past 6 months if the patient has not been on this treatment previously)? □ Yes □ No *_Please provide documentation_

Is the patient's creatinine clearance 60ml/min or greater? □ Yes □ No

Does the patient have established cardiovascular disease as described as ischemic heart disease and/or cerebrovascular disease and/or peripheral arterial disease? □ Yes □ No *_Please provide documentation._

Is the patient a 55 year old(or older) male with dyslipidemia, hypertension and/or who smokes 5 or more cigarettes/day? □ Yes □ No

Is the patient a 60 year old(or older) female with dyslipidemia, hypertension and/or who smokes 5 or more cigarettes/day? □ Yes □ No

<u>For patient with heart failure with or without diabetes, answer the following:</u>

Has patient ever had NYHA class II, III, or IV symptoms of heart failure? □ Yes □ No *_Please provide documentation_

Does patient have ejection fraction of 40% or less? □ Yes □ No *_Please provide documentation_

<u>For patients with chronic kidney disease with or without diabetes, answer the following</u>:

Does patient have and estimated GFR(eGFR) that equals between 25-75ml/min/1.73m^2 (inclusive)? □ Yes □ No *_Please provide documentation_

Has patient been on an ACE inhibitor or ARB for at least one month? □ Yes □ No

Does patient have an absolute contraindication to the ACE inhibitor or ARB drug class? □ Yes □ No

Does patient have Type 1 diabetes? □ Yes □ No
Does patient have polycystic kidney disease? □ Yes □ No

Does patient have lupus nephritis? □ Yes □ No
Does patient have ANCA-associated vasculitis? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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