



**InvokametXR (Canagliflozin/metformin ext rel)**  
**Prior Authorization Request Form**



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

**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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page*





**InvokametXR (Canagliflozin/metformin ext rel)**  
**Prior Authorization Request Form**



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

MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Type II diabetes <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<b>Clinical information:</b> Is the patient's estimated glomerular filtration rate (GFR) below 30 mL/min/1.73 m2? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide documentation.</i>  Is the patient's most recent (pre-InvokametXR) HgbA1C obtained in the past 6 months 7% or greater? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation</i>  Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No  Is the patient currently on metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No  Did the patient have an inadequate response or intolerance to metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation</i>  Does the patient have at least one of the following contraindications to metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please Check one) <input type="checkbox"/> Estimated glomerular filtration rate (GFR) less than or equal to 30 mL/min/1.73 m2 <input type="checkbox"/> Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy  Is the patient currently taking at least one of the following anti-hyperglycemic agents, such as a meglitinide like nateglinide, repaglinide, or insulin, or a sulfonylurea like glimepiride, glyburide, or glipizide? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide documentation.</i>  Does patient have a true medical contraindication to sulfonylureas? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please Check one) <input type="checkbox"/> High risk for falls <input type="checkbox"/> Concurrent use with warfarin <input type="checkbox"/> Serum creatinine level exceeding 1.8mg/dL <input type="checkbox"/> Estimated glomerular filtration rate (GFR) less than or equal to 30 mL/min/1.73 m2 <input type="checkbox"/> History of sulfa-induced Stevens-Johnson syndrome <input type="checkbox"/> History of sulfa-induced toxic epidermal necrolysis <input type="checkbox"/> History of sulfa allergy		





**InvokametXR (Canagliflozin/metformin ext rel)  
Prior Authorization Request Form**

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



MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

Is patient 30 years or older?  Yes  No

Is the patient's most recent hemoglobin A1c level within the past 6 months equals 7.0 - 10.5%, inclusive?

Yes  No *Please provide documentation.*

Does patient have symptomatic atherosclerotic cardiovascular disease?  Yes  No

Please select at least one of the following characterizations :

- History of stroke
- Hospital admission for unstable angina
- History of coronary revascularization procedure
- History of peripheral revascularization procedure
- History of amputation secondary to peripheral vascular disease
- Patient is symptomatic with documented hemodynamically-significant carotid or peripheral vascular disease

Is the patient 50 years of age or older AND has 2 or more of the following risk factors?  Yes  No

Please select at least 2 of the following risk factors AND provide chart documentation:

- Duration of diabetes of 10 years or longer
- Systolic blood pressure is greater than 140mmHg while receiving antihypertensive medication
- Current daily cigarette smoker
- Documented albuminuria
- Documented HDL-cholesterol equaling less than 39mg/dL AND patient's estimated glomerular filtration rate(GFR) is above 30mL/minute/1.73m<sup>2</sup>

Is the patient's most recent hemoglobin A1c level within the past 6 months equals 6.5 - 12%, inclusive?  Yes  No

*Please provide documentation.*

Is the patient's estimated glomerular filtration rate (GFR) equal to 30 to less than 90 mL/min/1.73 m<sup>2</sup>?  Yes  No

*Please provide documentation.*

Is the patient's urinary albumin(mcg/L)-to-creatinine (mG/L) ratio greater than 300?  Yes  No

*Please provide documentation.*

Is patient currently receiving treatment with an ACE inhibitor or an ARB(angiotensin receptor blocker)?  Yes  No

*Please provide documentation.*

Was the patient intolerant of past treatment with ACE inhibitors or ARBs?  Yes  No

*Please provide documentation.*

Does patient have nondiabetic renal disease?  Yes  No

Does patient's renal disease require immunosuppressant, chronic dialysis or renal transplant?  Yes  No





**InvokametXR (Canagliflozin/metformin ext rel)  
Prior Authorization Request Form**

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



**MEMBER'S LAST NAME:** \_\_\_\_\_ **MEMBER'S FIRST NAME:** \_\_\_\_\_

**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.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

