

Kombiglyze XR (saxagliptin; metformin) 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.

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): W	EIGHT (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: <u>HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF</u>

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:		
		IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):					

Continued on next page.







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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHE	R 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 1 diabetes Type 2 diabetes Other DiagnosisICD-10 C 	: PLEASE PROVIDE ALL RELEVANT CLINIC.		
Is the patient already taking the reque			
Is the patient's HbA1c 7% or greater? * HbA1c must be taken within the pas	□ Yes □ No t 6 months. Copy of HbA1c level require		
Was the patient's most recent HbA1c • Yes • No *Copy of HA1c level required.	level, PRIOR to STARTING the requested	d medication, 7.0% or greater?*	
Is the patient currently on metformin [*] *Please provide documentation	?* □ Yes □ No		
Has the patient had an inadequate rest *Please provide documentation.	sponse or intolerance to metformin?*	🗆 Yes 🗆 No	
Estimated glomerular filtration rate	the following contraindication to metfo (GFR) less than or equal to 45 mL/min/ s, portal hypertension, ascites, and/or h	1.73 m2;	
Is the patient currently taking one of t Adlyxin (lixisenatide) 	the below? (Please Circle)		
 Glyxambi(linagliptin/empaglifloz Byetta, Bydureon (exenatide) Janumet/Janumet XR (sitagliptin Tradjenta (linagliptin) Onglyza (saxagliptin) 			
 Oseni (alogliptin-pioglitazone) Trulicity (dulaglutide) Victoza (liraglutide) Ozempic(semaglutide) Nesina (alogliptin) 			
Jentadueto (linagliptin and metfor 2017–2023 by Magellan Rx Management, LLC.			
Revision Date: 10/01/2022			





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- Kombiglyze XR (saxagliptin and metformin)
- Kazano (alogliptin and metformin)

Will the drug be discontinued?

Yes
No

- Adlyxin (lixisenatide)
- Glyxambi(linagliptin/empagliflozin)
- Byetta, Bydureon (exenatide) •
- Januvia(sitagliptin)
- Janumet/Janumet XR (sitagliptin and metformin)
- Tradjenta (linagliptin) •
- **Onglyza** (saxagliptin) ٠
- Oseni (alogliptin-pioglitazone)
- Trulicity (dulaglutide)
- Victoza (liraglutide) ٠
- **Ozempic(semaglutide)** •
- Nesina (alogliptin) ٠
- Jentadueto (linagliptin and metformin)
- Kazano (alogliptin and metformin)

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

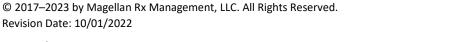
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FAX THIS FORM TO: 800-424-7640

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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