

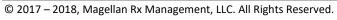
## Rybelsus (semaglutide) Prior Authorization Request Form



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

MEMBER'S LAST NAME:		MEMBER'S FIRST NAME:		
	, chart notes or lab data, to sup		ch any additional documentation that ation request). Information contained	
				RGENT
MEMBER INFORMATION				GLIVI
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE ID NUI	VIBER:			
FYOU ARE NOT THE PATIENT OR THE PRESCR FOLLOWING LINK: <u>HTTPS://MAGELLANRX.COL</u>	GHT (IN/CM): WEIGH  IBER, YOU WILL NEED TO SUBMIT A PHI DISCLO  M/MEMBER/EXTERNAL/COMMERCIAL/COMME  RESENTATIVE (IF APPLICABLE):	SURE AUTHORIZATION FOR DN/DOC/EN-US/PHI DISCLO	RM WITH THIS REQUEST WHICH CAN BE FOUND AT THE DSURE AUTHORIZATION.PDF	
	/E'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/REFILI	QUANTITY:	
NEW THERAPY DURATION OF THERAPY (SPE	RENEWAL CIFIC DATES):	IF RENEWAL: DA	TE THERAPY INITIATED:	

Continued on next page



Revision Date: 10.15.2022 CAT0010







## Rybelsus (semaglutide) 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 OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
☐ Type II diabetes☐ Other diagnosis:	ICD-10 Code(s):		
	· ·		
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION. Lab Values:	: PLEASE PROVIDE ALL RELEVANT CLINIC	CAL INFORMATION TO SUPPORT A	
greater? □ Yes □ No  Documentation of HbA1c level require	in the past 6 months or prior to starting ed. filtration rate (GFR) less than or equal t		
Clinical information: Does the patient have advanced liver If yes, please select:  Ascites Cirrhosis Hepatic encephalopathy Portal hypertension	disease with at least one of the following	ng? □Yes □No	
Has the patient tried or is the patient	currently taking metformin?   Yes	No	
Has treatment with metformin been a	avoided due to lactic acidosis or elevate	d liver enzymes? □ Yes □ No	
If <u>yes</u> , please select:  ☐ Janumet/Janumet XR (sitagliptin/m ☐ Januvia (sitagliptin)	rtin/metformin) □ Kazano (alogliptin/m min)		

© 2017 – 2018, Magellan Rx Management, LLC. All Rights Reserved.

Revision Date: 10.15.2022 CAT0010





## Rybelsus (semaglutide) Prior Authorization Request Form



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

MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
□ Seglujan(ertugliflozin/sitagliptin) □ Qtern( dapagloflozin/saxagliptin)			
If the patient is taking any of the above medi discontinued? ☐ Yes ☐ No	ications, will concomitant therapy with those medications be		
Are there any other comments, diagnoses, sy physician feels is important to this review?	ymptoms, medications tried or failed, and/or any other information the		
<b>Please note:</b> Not all drugs/diagnosis are cover information is received.	red on all plans. This request may be denied unless all required		
•	ded is true and accurate to the best of my knowledge. I understand that designees may perform a routine audit and request the medical of the information reported on this form.		
Prescriber Signature or Electronic I.D. Verifica	ation: Date:		
you are not the intended recipient, you are hereby notif	ing this transmission contain confidential health information that is legally privileged. If fied that any disclosure, copying, distribution, or action taken in reliance on the contents ceived this information in error, please notify the sender immediately (via return FAX)		

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

 $\textbf{MAIL REQUESTS TO:} \ \text{Magellan Rx Management Prior Authorization Program}$ 

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811



and arrange for the return or destruction of these documents.