Synjardy (empagliflozin/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.

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

Continued on next page

© 2017 – 2018, Magellan Health, Inc. All Rights Reserved.

Synjardy (empagliflozin/metformin)
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? ☐ 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 □ Other Diagnosis_____________ICD-10 Code(s):___________	

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

Clinical information:

Is the patient's estimated glomerular filtration rate (eGFR) below 30 mL/min/1.73 m2? □ Yes □ No
Please provide documentation.

Is the patient's most recent (pre-Synjardy) HgbA1C obtained in the past 6 months 7% or greater? □ Yes □ No
****Please provide documentation***

Is the patient on dialysis? □ Yes □ No

Is the patient currently on metformin? □ Yes □ No

Did the patient have an inadequate response or intolerance to metform? □ Yes □ No
****Please provide documentation***

Does the patient have at least one of the following contraindications to metformin? □ Yes □ No
(Please Check one)
□ Estimated glomerular filtration rate (eGFR) less than or equal to 30 mL/min/1.73 m2
□ 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? □ Yes □ No
Please provide documentation.

Does patient have a true medical contraindication to sulfonylureas? □ Yes □ No
(Please Check one)
□ High risk for falls
□ Concurrent use with warfarin
□ Serum creatinine level exceeding 1.8mg/dL
□ Estimated glomerular filtration rate (GFR) less than or equal to 30 mL/min/1.73 m2
□ History of sulfa-induced Stevens-Johnson syndrome
□ History of sulfa-induced toxic epidermal necrolysis
□ History of sulfa allergy

© 2017 – 2018, Magellan Health, Inc. All Rights Reserved.

Magellan Rx MANAGEMENT℠

Synjardy (empagliflozin/metformin)
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 the patient's most recent hemoglobin A1c level within the past 6months 7.0-10%, inclusive? □ **Yes** □ **No**
Please provide documentation.

Does the patient's body mass index(BMI) exceed 45kg/m² ? □ **Yes** □ **No**

Is the patient's estimated glomerular filtration rate (eGFR) above 30 mL/min/1.73 m2? □ **Yes** □ **No**
Please provide documentation.

Is the patient's medical history positive for at least one of the following? □ **Yes** □ **No**
Please check at least one of the following:

- □ **MI or Stroke**
- □ **Imaging shows single-vessel or multi-vessel coronary artery disease**
- □ **Previous coronary revascularization procedure**
- □ **Positive cardiac stress test**
- □ **Hospital admission for unstable angina**
- □ **Occulsive peripheral arterial disease (defined as limb revascularization procedure, limb or foot amputation due to circulatory insufficiency, imaging or non-invasive study showing evidence of more than 50% stenosis in an artery, and/or ankle: brachial index equaling less than 0.9 in an ankle.)**

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

© 2017 – 2018, Magellan Health, Inc. All Rights Reserved.

Magellan Rx MANAGEMENT℠