



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





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:
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2. LIST DIAGNOSES: ICD-10:

<input type="checkbox"/> Type II diabetes <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____	ICD-10:
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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-SynjardyXR) 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 metformin? 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





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
- Occlusive 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:** _____

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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

