Trijardy XR (empaglifozin, linagliptin and 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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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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 ☐ Type-II Diabetes (with established cardiovascuar disease) ☐ Other diagnosis: _____ICD-10_____	

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

Clinical Information:

Does the patient have an estimated glomerular filtration rate greater than 45 mL/min/1.73 m^2 ?
☐ Yes ☐ No (please provide documentation)

Is the patient on dialysis? ☐ Yes ☐ No

Is the patient's most recent hemoglobin A1c greater than or equal to 7%?
☐ Yes ☐ No (please provide documentation)

Does the patient's most recent hemoglobin A1c equal 7 to 10.5%, inclusive?
☐ Yes ☐ No (please provide documentation)

Is the patient's BMI 45 kg/m^2 or less? ☐ Yes ☐ No (please provide documentation)

Is the patient currently on metformin? ☐ Yes ☐ No

Is the patient currently on, failed treatment with, had an intolerance to, has a true medical contraindication (such as a high risk for falls, will take warfarin with, a serum creatinine level exceeding 1.8mg/dL, an estimated GFR level less than 30mL/min/1.73 m^2, a history of Stevens-Johnson syndrome, a history of sulfa-induced toxic epidermal necrolysis or a history of sulfa allergy) to a sulfonylurea, a meglitinide, or insulin?
☐ Yes ☐ No (please provide documentation)

Is the patient's medical history positive for any of the following: MI, Stroke, Imaging showing 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)?
☐ Yes ☐ No (please provide documentation)

Has the patient failed to reach HbA1c goal when treated with the individual components of Trijardy XR separately?
☐ Yes ☐ No

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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:** _____

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