



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

MEMBER'S LAST NAME:		MEMBER'S FIRST N	MEMBER'S FIRST NAME:	
	, chart notes or lab data, t		any additional documentation that is on request). Information contained in	
this form is i rotected freditif	mormation under rin AA.		☐ URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:	DATE OF BIRTH:	
STREET ADDRESS:				
CITY:		STATE: ZI	P CODE:	
PATIENT INSURANCE ID NU	MBER:			
MALE FEMALE HEIGHT ON THE PRESCRIPTION OF THE	IBER, YOU WILL NEED TO SUBMIT A PHI E	DISCLOSURE AUTHORIZATION FORM W COMMON/DOC/EN-US/PHI DISCLOSE	ITH THIS REQUEST WHICH CAN BE FOUND AT THE URE AUTHORIZATION.PDF	
AUTHORIZED REPRESENTATI				
PRESCRIBER INFORMATION				
LAST NAME:		FIRST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:	DEA NUMBER:	
PHONE NUMBER:		FAX NUMBER:	FAX NUMBER:	
STREET ADDRESS:				
CITY:		STATE: ZI	P CODE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PE	OFFICE CONTACT PERSON:	
MEDICATION OR MEDICAL	DISPENSING INFORMATION	ON		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
☐ NEW THERAPY	RENEWAL	IF RENEWAL: DATE	THERAPY INITIATED:	
DURATION OF THERAPY (SP	ECIFIC DATES):			
Continued on next page.				

Cater fill arof Confidential Green

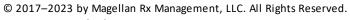






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MEMBER'S LAST NAME:	IEMBER'S LAST NAME: MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
BROG WINE HAD BOSKES.	57(125).	TAILONE/ALLENGT.		
2. LIST DIAGNOSES:		ICD-10:		
□ Type II diabetes				
□ Other diagnosis:	ICD-10			
	N: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A		
PRIOR AUTHORIZATION.				
Lab Values:	in the neet Compaths or prior to stout	ing the requested medication 7.0% or		
Was the patient's most recent HbA1c in the past 6 months or prior to starting the requested medication 7.0% or greater? □ Yes □ No Documentation of HbA1c level required.				
Is the patient's estimated glomerular filtration rate (GFR) less than or equal to 45 mL/min/1.73 m2? ☐ Yes ☐ No Documentation of GFR required.				
Does the patient currently have a serum creatinine level exceeding 1.8 mg/dL or an estimated GFR less than 30 mL/min/1.73 m2? Output Property No Documentation required.				
Clinical Information: Has the patient tried or is the patient currently taking metformin? Yes No				
Has treatment with metformin been avoided due to lactic acidosis or elevated liver enzymes? ☐ Yes ☐ No				
Does the patient have advanced liver If yes, please select: Ascites Cirrhosis Hepatic encephalopathy Portal hypertension	r disease with at least one of the follow	ving? □ Yes □ No		
Is the patient currently taking any of the following medications? Yes No If <u>yes</u> , please select: Janumet/Janumet XR (sitagliptin/metformin) Januvia (sitagliptin)				
□ Jentadueto/Jentadueto XR (linagenerale linagenerale)□ Kazano (alogliptin/metformin)				
☐ Kombiglyze XR (saxagliptin/metfolio☐ Nesina (alogliptin)	ormin)			
□ Onglyza (saxagliptin)				
☐ Oseni (alogliptin/pioglitazone)				
□ Tradjenta (linagliptin)				
☐ Glyxambi (empagliflozin/linaglipt				
□ Seglujan (ertugliflozin/sitagliptin)				



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:
□ Qtern (dapagliflozin/saxagliptin)	
If the patient is taking any of the above medications, discontinued? \Box Yes $\ \Box$ No	will concomitant therapy with those medications be
Type II diabetes with established cardiovascular disea	nse:
Is the most recent HgbA1c in the past 6months, prior to No Documentation required.	o starting the requested GLP-1 product 9.5% or less? \square Yes \square
Is patient currently taking up to two diabetic medicat required.	ions, with or without insulin? Yes No Documentation
cerebrovascular disease, or peripheral vascular disease. Please check at least one of the following with docum History of MI or stroke or transient ischemic attack History of unstable angina with ECG changes History of coronary revascularization procedure History of carotid revascularization procedure History of peripheral revascularization procedure	entation in submitted chart notes:
	or imaging of coronary, carotid or lower extremities arteries ated by positive nuclear imaging test or exercise test or stress
Is patient 55 to 59 years of age, inclusive, with subclinic Please check at least one of the following with docum myocardial ischemia,	cal vascular disease? Yes No Documentation required. entation in submitted chart notes:
□ coronary, carotid, or lower extremity artery stenosi	s exceeding 50%,
 □ left ventricular hypertrophy, □ estimated glomerular filtration rate (eGFR) less than □ albuminuria 	60 mL/min per 1·73 m², or
Is patient age 60 years or older AND has at least 2 or of Documentation required. Please check at least two of the following with docum tobacco use, dyslipidemia, hypertension, or abdominal obesity	
Are there any other comments, diagnoses, symptoms, physician feels is important to this review?	medications tried or failed, and/or any other information the

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Please note: Not all drugs/diagnosis are covered on al information is received.	l plans. This request may be denied unless all required
·	ue and accurate to the best of my knowledge. I understand that es may perform a routine audit and request the medical ormation reported on this form.
Prescriber Signature or Electronic I.D. Verification:	Date:
you are not the intended recipient, you are hereby notified that an	ismission contain confidential health information that is legally privileged. If by disclosure, copying, distribution, or action taken in reliance on the contents information in error, please notify the sender immediately (via return FAX)

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 Phone: 877-228-7909

