



Xigduo XR (dapagliflozin/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: _____

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):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Type II diabetes for blood glucose control <input type="checkbox"/> Heart Failure with diabetes <input type="checkbox"/> Type II diabetes with established cardiovascular disease and/or with additional cardiovascular risk <input type="checkbox"/> Chronic kidney disease with Type II diabetes <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p><u>For patient with Type II Diabetes only, answer the following:</u></p> <p>Is the patient's estimated glomerular filtration rate (GFR) below 60 mL/min/1.73 m2?* <input type="checkbox"/> Yes <input type="checkbox"/> No *Please provide documentation.</p> <p>Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the patient's hemoglobin A1C (HbA1c) 7.0% or greater prior to therapy (HbA1c must be taken within the past 6 months if the patient has not been on this treatment previously)?* <input type="checkbox"/> Yes <input type="checkbox"/> No *Copy of HbA1c level required.</p> <p>Is the patient currently on metformin?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient had an inadequate response or intolerance to metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No *Please provide documentation</p> <p>Does the patient have at least one of the following contraindication to metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please Check one) <input type="checkbox"/> Estimated glomerular filtration rate (GFR) less than or equal to 30 mL/min/1.73 m2 <input type="checkbox"/> Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy</p>		
<p><u>For patient with Type II diabetes with established cardiovascular disease and/or risks, answer the following:</u></p> <p>Is the patient 40 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have Type II diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		





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Is patient's most recent HgbA1c level in the past 6months AT LEAST 6.5% and is LESS THAN 12.0% prior to therapy (HbA1c must be taken within the past 6 months if the patient has not been on this treatment previously)? Yes No **Please provide documentation.*

Is the patient's creatinine clearance 60ml/min or greater? Yes No

Does the patient have established cardiovascular disease as described as ischemic heart disease and/or cerebrovascular disease and/or peripheral arterial disease? Yes No **Please provide documentation.*

Is the patient a 55 year old(or older) male with dyslipidemia, hypertension and/or who smokes 5 or more cigarettes/day? Yes No

Is the patient a 60 year old(or older) female with dyslipidemia, hypertension and/or who smokes 5 or more cigarettes/day? Yes No

For patient with heart failure with diabetes, answer the following:

Has patient ever had NYHA class II, III, or IV symptoms of heart failure? Yes No **Please provide documentation*

Does patient have ejection fraction of 40% or less? Yes No **Please provide documentation*

Does patient have Type II diabetes? Yes No

For patients with chronic kidney disease with Type II diabetes, answer the following:

Does patient have Type II diabetes? Yes No

Does patient have and estimated GFR(eGFR) that equals between 25-75ml/min/1.73m² (inclusive)? Yes No **Please provide documentation*

Has patient been on an ACE inhibitor or ARB for at least one month? Yes No

Does patient have an absolute contraindication to the ACE inhibitor or ARB drug class? Yes No

Does patient have Type 1 diabetes? Yes No

Does patient have polycystic kidney disease? Yes No

Does patient have lupus nephritis? Yes No

Does patient have ANCA-associated vasculitis? Yes No

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/diagnoses are covered on all plans. This request may be denied unless all required information is received.





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

