Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pharmacy Benefits Prior Authorization Help Desk
SGLT2 inhibitor for treatment of DM2 Prior Authorization (PA)

Instructions:

This form is used by participating providers for coverage of **Sodium-glucose co-transporter 2 (SGLT2) inhibitors for type 2 diabetes mellitus (DM2).** Please complete and fax this form back to Kaiser Permanente within 24 hours at fax: 1-866-331-2104. If you have any questions or concerns please call 1-866-331-2103. **Request will not be considered unless form is completely filled out.**

KP-MAS Formulary can be found at www.providers.kp.org/mas/formulary.html

A. Patient Information

Patient Name:	Kaiser ID (if available):
Patient Date of Birth:	Patient Phone Number:

B. Provider Information

Provider Name:	Provider Address:
Provider NPI:	Provider Phone Number:
Provider Fax Number:	

Please check the box that applies:

□ Standard Review (72 hours)

□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature____

C. Pharmacy Information

Pharmacy Name:	NABP/NPI #:
Pharmacy Phone Number:	Pharmacy Fax Number:

D. Drug Information

Drug Name and Strength:	Quantity and Days Supply:
Directions (SIG):	Date Requested:

E. LENGTH OF AUTHORIZATION : 1 Year

1. Does patient have diagnosis of diabetes mellitus type 2?
☐ Yes, please go to question 2 ☐ No [If no, then no further questions required]

2. Is patient over 18 years old?
☐ Yes, please go to question 3 ☐ No [If no, then no further questions required]

3. Does patient have an A1c over 7% AND lab results within 90 days?
☐ Yes, answer and go to question 4 ☐ No [If no, then no further questions required]
A1c goal_____% Value_____% Date________

4. Does patient have any contraindications to SGLT2 inhibitors including: severe renal impairment (CrCl <30 ml/min), end-stage-renal-disease (ESRD), dialysis treatment, or hypersensitivity reactions to SGLT2 inhibitors?
☐ No, please go to question 5 ☐ Yes [If yes, then no further questions required]

5. Is this request for the preferred SGLT2 inhibitor, Empagliflozin (Jardiance)?
☐ Yes, please go to question 6 ☐No (If no, please provide medical necessity for non-formulary SGLT2 inhibitor and complete the rest of the form)
Rationale ____

6. Does patient have a GFR over 60 mL/min/1.73 m^2 if requesting dapagliflozin (Farxiga) AND lab result within 90 days? OR a GFR over 45 mL/min/1.73 m^2 if requesting empagliflozin (Jardiance) or canagliflozin (Invokana) AND lab result in 90 days?
☐ Yes, answer and go to question 7 ☐No (If no, please provide rationale)____________________________
GFR ____ mL/min/1.73 m^2 Date_______

7. Patient has demonstrated adequate trial (90 days) and adherence to metformin at maximum tolerated dose unless contraindicated?

☐ Yes, please sign and fax the form ☐ No (If no, recommend trial of metformin))

Requests for Renewal (adults)

Renewal is contingent upon prescriber affirmation of patient achieving personal A1c goal

F. Addition Information

Is there any additional information that would help in the decision making process? If so please describe.

G. Provider Sign off

Provider Signature:	Date:

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