Updated: 02/2020
DMMA Approved: 02/2020

Request for Prior Authorization for Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Prior Authorization Criteria:

For all requests for Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Incretin Mimetics all of the following criteria must be met:

Coverage may be provided with a diagnosis of type 2 diabetes mellitus and the following criteria is met:

- The member must have tried and failed a minimum of a 4 week trial or had an intolerance or contraindication to any version of metformin or a combination metformin product
- For non-preferred agents must provide documentation of a trial and failure of 2 preferred agents in the same class or submit a clinical reason for not having tried the preferred agents
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
        - Documentation the member has at least 1 fill of the requested medication in the past 45 days
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. Delaware HEALTH OPTIONS

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Sodium-Glucose co-Transporter 2 (SLGT2) Inhibitors and Incretin Mimetics
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	
Health Options ID:	DOB:

DRUG INFORMATION

Medication requested:	Strength
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

BILLING INFORMATION

This medication will be billed: ☐ at a retail pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

PLACE OF SERVICE INFORMATION

Name:	**NPI:**
Address:	**Phone:**

MEDICAL HISTORY

Member's Diagnosis: ☐ Type 2 Diabetes ☐ Other _____ Diagnosis Code:_____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION CRITERIA

Has the member been on a SGLT2-inhibitor or Incretin Mimetic within the last 45 days? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	Date