Updated: 02/2022
DMMA Approved: 02/2022

Request for Prior Authorization for Preferred Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors GLP-1 Receptor Agonists, and Dipeptidyl Peptidase IV (DPP-IV) Inhibitors
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors, GLP-1 Receptor Agonists, and Dipeptidyl Peptidase IV (DPP-IV) 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 Preferred Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and the diagnosis is Type 2 diabetes all of the following criteria must be met:

- Claims will pay at the point of sale when a diagnosis of Type 2 diabetes is entered

For all requests for Preferred Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and the diagnosis is Heart Failure (HF) all of the following criteria must be met:

- Documentation the member's HF is NYHA class II-IV
- Member must be 18 years of age or older
- Must be prescribed by or in consultation with a cardiologist
- Member must have a reduced left ventricular ejection fraction of 40% or less
- Member has tried and failed (which will be verified via pharmacy claims if available) had an intolerance, contraindication, or is currently taking at least **two** of the following:
    - Beta blocker
    - ACEi/ARB/ARNI
    - Diuretic
    - Aldosterone antagonist (if an aldosterone antagonist is indicated)
- 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

For all requests for Preferred GLP-1 Receptor Agonists all of the following criteria must be met:

- Claims will pay at the point of sale when a diagnosis of Type 2 diabetes is entered.

For all requests for Preferred Dipeptidyl Peptidase IV (DPP-IV) Inhibitors all of the following criteria must be met:

- Claims will pay at the point of sale when both of the following is met:
    - A diagnosis for Type 2 diabetes is entered at the point of sale.

  - The member has filled metformin or a metformin containing product in the past 90 days.
  - For any request that does not meet automatic point of sale approval all of the following criteria must be met:
    - Documentation the member has a diagnosis of Type 2 diabetes
    - Documentation the member has tried and failed or has an intolerance or contraindication to any version of metformin or a metformin combination product.
    - **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 HEALTH OPTIONS

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Sodium-Glucose co-Transporter 2 (SLGT2) Inhibitors GLP-1 Receptor Agonists, and Dipeptidyl Peptidase IV (DPP-IV) Inhibitors
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) 325-6251 Monday through Friday 8:00am to 7:00pm

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:	Strength:	
Directions:	Quantity:	Refills:
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 ☐ Heart Failure ☐ Other _____ ICD-10: _____

If the diagnosis is for Type 2 diabetes and the requested medication is a DPP-IV inhibitor: has the member tried and failed metformin or a metformin containing product?
☐ Yes ☐ No
If no please explain why the member cannot try metformin: _____
_____

If the diagnosis is HF please answer the following two questions:
1. Does the member have heart failure with a NYHA class II-IV and a reduced ejection fraction ≤ 40%?
   ☐ Yes ☐ No

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2. Please mark which of the following the member has tried and failed or had a contraindication to:
   - ☐ Beta blocker
   - ☐ ACEi/ARB/ARNI
   - ☐ Diuretic
   - ☐ Aldosterone antagonist (if an aldosterone antagonist is indicated)

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, GLP-1 Receptor Agonists, and Dipeptidyl Peptidase IV (DPP-IV) Inhibitors within the last 45 days? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	**Date**