Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Hypoglycemics, SGLT2 Inhibitors

A. Prescriptions That Require Prior Authorization

All prescriptions for Hypoglycemics, SGLT2 Inhibitors must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Hypoglycemics, SGLT2 Inhibitor, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Hypoglycemic, SGLT2 Inhibitor for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. For the treatment of type 2 diabetes, has a documented history of **one** of the following:

   a. Failure to achieve glycemic control as evidenced by the beneficiary's HbA1c values using maximum tolerated doses of metformin,

   b. A contraindication or intolerance to metformin,

   c. Requires initial dual therapy with metformin based on HbA1c as defined by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology,

   d. For a Hypoglycemic, SGLT2 Inhibitor with proven cardiovascular disease (CVD), heart failure (HF), or chronic kidney disease (CKD) benefit, has CVD (or two risk factors for CVD as identified by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology), HF, or CKD;

   AND

3. For a non-preferred Hypoglycemics, SGLT2 Inhibitor, has a history of therapeutic failure, contraindication, or intolerance of the preferred Hypoglycemics, SGLT2 Inhibitors. See the Preferred Drug List (PDL) for the list of preferred Hypoglycemics, SGLT2 Inhibitors at: https://papdl.com/preferred-drug-list

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Hypoglycemics, SGLT2 Inhibitor. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

Gateway Health
It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

HYPOGLYCEMICS, SGLT2 INHIBITORS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Does the beneficiary have a diagnosis of type 2 diabetes?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
Requests for a NON-PREFERRED medication: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred Hypoglycemics, SGLT2 Inhibitors? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class.*	☐Yes ☐No *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- ☐Has a history of trial and failure of maximum tolerated doses of metformin as evidenced by HbA1c results
- ☐Has a contraindication or intolerance to metformin
- ☐Requires initial dual therapy with metformin based on HbA1c based on current ADA and/or AACE/ACE guidelines
- ☐Will be taking metformin in combination with the requested SGLT2 inhibitor
- ☐Has the following comorbidities:
  - ☐cardiovascular disease or at least 2 risk factors for cardiovascular disease
  - ☐heart failure
  - ☐chronic kidney disease

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: