US Family Health Plan

Prior Authorization Request Form for

canagliflozin / metformin **(Invokamet, Invokamet XR)**, dapagliflozin / metformin **(Xigduo XR), and ertugliflozin / metformin (Segluromet)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD. **The formulary alternatives on the DoD Uniform Formulary are: empagliflozin (Jardiance), empagliflozin/linagliptin (Glyxambi), and empagliflozin/metformin (Synjardy/Synjardy XR).**

The completed form may be **faxed** to **617-562-5296**
OR
The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
	_____		_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient had an inadequate response to metformin?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried one of the preferred products (Jardiance, Glyxambi, Synjardy, Synjardy XR) and experienced a significant adverse event that is not expected to occur with the requested agent?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[06 March 2018]