

US Family Health Plan
Prior Authorization Request Form for
**Canagliflozin (Invokana), Dapagliflozin (Farxiga), Ertugliflozin (Steglatro),
Ertugliflozin/sitagliptin (Steglujan), and Bexagliflozin (Brenzavvy)**

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 completed form may be faxed to 855-273-5735

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

The preferred formulary SGLT2 inhibitors on the DoD Uniform Formulary are: empagliflozin (Jardiance), empagliflozin/metformin (Synjardy, Synjardy XR) and empagliflozin/linagliptin (Glyxambi).

Prior authorization does not expire.

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. Is the patient greater than or equal to 18 year(s) of age?	<input type="radio"/> Yes Proceed to question 2	<input type="radio"/> No STOP Coverage not approved
2. The provider is aware and acknowledges that empagliflozin (Jardiance), empagliflozin/metformin (Synjardy, Synjardy XR) and empagliflozin/linagliptin (Glyxambi) are DoD's preferred SGLT2 inhibitor, and that PA is not required for empagliflozin.	<input type="radio"/> Acknowledged Proceed to question 3	
3. What is the indication or diagnosis? Note: Non-FDA-approved uses are not approved, including type 1 diabetes mellitus, heart failure with preserved ejection fraction, or acute decompensated heart failure.	<input type="radio"/> Improved glycemic control in patient with Type 2 Diabetes Mellitus - Proceed to question 4 <input type="radio"/> Reduce the risk of cardiovascular death in patients with Type 2 Diabetes Mellitus AND established cardiovascular disease - Proceed to question 4 <input type="radio"/> Reduce kidney disease progression and improve cardiovascular outcomes in patients with Chronic Kidney Disease - Proceed to question 6 <input type="radio"/> Reduce risk of heart failure hospitalization and/or cardiovascular death in patients with Heart Failure with reduced ejection fraction (HFrEF) - Proceed to question 11 <input type="radio"/> Other - STOP Coverage not approved	
4. Has the patient experienced inadequate response, significant adverse effects, or have a contraindication to metformin?	<input type="radio"/> Yes Proceed to question 5	<input type="radio"/> No STOP Coverage not approved

5. Has the patient experienced inadequate response, significant adverse effects, or have a contraindication to a preferred SGLT2 inhibitor? The preferred SGLT2 inhibitors are Jardiance, Synjardy, Synjardy XR, and Glyxambi	<input type="radio"/> Yes Sign and date below	<input type="radio"/> No STOP Coverage not approved
6. Is the initial prescription written by or in consultation with a nephrologist?	<input type="radio"/> Yes Proceed to question 7	<input type="radio"/> No STOP Coverage not approved
7. Has the patient experienced significant adverse reactions or have a contraindication to empagliflozin?	<input type="radio"/> Yes Proceed to question 8	<input type="radio"/> No STOP Coverage not approved
8. Is the patient's estimated glomerular filtration rate (eGFR) higher than 25 ml/min/1.73m ² ?	<input type="radio"/> Yes Proceed to question 9	<input type="radio"/> No STOP Coverage not approved
9. Is the patient's Urinary Albumin-to-Creatinine Ratio greater than or equal to 200 mg/gram?	<input type="radio"/> Yes Proceed to question 10	<input type="radio"/> No STOP Coverage not approved
10. Is the patient receiving maximum tolerated labeled dose of an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin II receptor blocker (ARB), or is unable to use an ACEI or ARB?	<input type="radio"/> Yes Sign and date below	<input type="radio"/> No STOP Coverage not approved
11. Has the patient experienced significant adverse reactions or has a contraindication to empagliflozin?	<input type="radio"/> Yes Proceed to question 12	<input type="radio"/> No STOP Coverage not approved
12. Is the initial prescription written by or in consultation with a cardiologist?	<input type="radio"/> Yes Proceed to question 13	<input type="radio"/> No STOP Coverage not approved
13. Does the patient have a documented diagnosis of chronic HF (NYHA II-IV) with a left ventricular ejection fraction (LVEF) less than or equal to 40% and with continued heart failure symptoms?	<input type="radio"/> Yes Proceed to question 14	<input type="radio"/> No STOP Coverage not approved
14. Is the patient receiving appropriate guideline-directed medical therapy including the following: angiotensin-converting enzyme inhibitor (ACEI), angiotensin II receptor blocker (ARB), or angiotensin receptor neprilysin inhibitor (ARNI); beta blocker; and aldosterone antagonist, unless contraindicated or if the patient has experienced adverse effects or could not tolerate these therapies?	<input type="radio"/> Yes Sign and date below	<input type="radio"/> 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