US Family Health Plan
Prior Authorization Request Form for
canagliflozin **(Invokana) –** dapagliflozin **(Farxiga) –** ertugliflozin **(Steglatro) –** ertugliflozin/sitagliptin (**Steglujan**) – sotagliflozin (**Inpefa)**

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 alternatives on the DoD Uniform Formulary are: empagliflozin (Jardiance), empagliflozin/metformin (Synjardy, Synjardy XR) and empagliflozin/linagliptin (Glyxambi) are DoD's preferred SGLT2 inhibitor

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?	☐ Yes Proceed to question **2**	☐ 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.	☐ 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.	☐ Improved glycemic control in patient with Type 2 Diabetes Mellitus - Proceed to question **4** ☐ Reduce the risk of cardiovascular death in patients with Type 2 Diabetes Mellitus AND established cardiovascular disease - Proceed to question **4** ☐ Reduce kidney disease progression and improve cardiovascular outcomes in patients with Chronic Kidney Disease - Proceed to question **6** ☐ Reduce risk of heart failure hospitalization and/or cardiovascular death in patients with Heart Failure with reduced ejection fraction (HFrEF) - Proceed to question **11** ☐ Other - **STOP Coverage not approved**	
4. Has the patient experienced inadequate response, significant adverse effects, or have a contraindication to metformin?	☐ Yes Proceed to question **5**	☐ 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	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
6. Is the initial prescription written by or in consultation with a nephrologist?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient experienced significant adverse reactions or have a contraindication to empagliflozin?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient's estimated glomerular filtration rate (eGFR) higher than 25 ml/min/1.73m2?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient's Urinary Albumin-to-Creatinine Ratio greater than or equal to 200 mg/gram?	☐ Yes Proceed to question **10**	☐ 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?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Has the patient experienced significant adverse reactions or has a contraindication to empagliflozin?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the initial prescription written by or in consultation with a cardiologist?	☐ Yes Proceed to question **13**	☐ 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?	☐ Yes Proceed to question **14**	☐ 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?	☐ 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 _____