



Please Note: Medical Necessity Prior Authorization may be overridden for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

## PRIOR AUTHORIZATION **BYPASS** **Invokamet® (canagliflozin/ metformin)**

Bypass the Prior Authorizaton by Modifying the following Prescription Forms to the Patient's Needs

Name \_\_\_\_\_  
 Address \_\_\_\_\_

**Rx**

Refer for  
 Diabetes/ Insulin  
 Protocol

MD \_\_\_\_\_  
 Signature \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_

**Rx** metformin 1000mg ER  
 quantity #  
 sig: 1 2x/daily

as directed by physician

Dx: DIABETES

ICD 10: E 13.9  
 MD \_\_\_\_\_  
 Signature \_\_\_\_\_

# SAMPLE



**Prescriber Information**

<b>Last Name:</b> <input type="text"/> <b>DEA/NPI:</b> <input type="text"/> <b>Phone</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>Specialty:</b> <input type="text"/> <b>Fax</b> <input type="text"/>
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**Member Information**

<b>Last Name:</b> <input type="text"/> <b>Member ID Number</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>DOB:</b> <input type="text"/>
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**Medication Information:**

<b>Drug Name and Strength:</b> <input type="text"/> <b>Diagnosis:</b> <input type="text"/>	<b>Quantity and Dosing:</b> <input type="text"/> <b>Duration:</b> <input type="text"/>
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When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

**Invokana, Invokamet, Jardiance, & Synjardy Prior Authorization Form**

You must answer ALL of the following questions		
1. Is the patient 18 years of age or older?	Y	N
2. What is the patient's diagnosis? <b>(Please Circle)</b>		
<ul style="list-style-type: none"> <li>• Type 2 diabetes</li> <li>• Type 1 diabetes</li> <li>• Other: _____</li> </ul>		
3. Does the patient have an estimated glomerular filtration rate greater than 45mL/min/1.73m <sup>2</sup> ? <i>Please provide documentation.</i>	Y	N
4. Is the patient currently on dialysis?	Y	N
5. Is the patient currently taking any of the following therapies? <b>(Please Circle)</b>	Y	N
<ul style="list-style-type: none"> <li>• Byetta, Bydureon (exenatide)</li> <li>• Januvia (sitagliptin)</li> <li>• Jentadueto (linagliptin / metformin)</li> <li>• Kombiglyze XR (saxagliptin / metformin)</li> <li>• Victoza (liraglutide)</li> <li>• Nesina (alogliptin)</li> <li>• Glyset (miglitol)</li> <li>• Trulicity (dulaglutide)</li> <li>• Oseni (alogliptin / pioglitazone)</li> <li>• Symlin (pramlintide)</li> </ul>		



<ul style="list-style-type: none"> <li>• Precose (acarbose)</li> <li>• Onglyza (saxagliptin)</li> <li>• Tradjenta (linagliptin)</li> <li>• Tanzeum (albiglutide)</li> <li>• Kazano (alogliptin / metformin)</li> <li>• Janumet/Janumet XR (sitagliptin / metformin)</li> <li>• Any other Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitor</li> </ul>		
<p>6. If the patient is on any of the therapies listed below, will these agents be discontinued? <b>(Please Circle)</b></p> <ul style="list-style-type: none"> <li>• Byetta, Bydureon (exenatide)</li> <li>• Januvia (sitagliptin)</li> <li>• Jentadueto (linagliptin / metformin)</li> <li>• Kombiglyze XR (saxagliptin / metformin)</li> <li>• Victoza (liraglutide)</li> <li>• Nesina (alogliptin)</li> <li>• Glyset (miglitol)</li> <li>• Trulicity (dulaglutide)</li> <li>• Oseni (alogliptin / pioglitazone)</li> <li>• Symlin (pramlintide)</li> <li>• Precose (acarbose)</li> <li>• Onglyza (saxagliptin)</li> <li>• Tradjenta (linagliptin)</li> <li>• Tanzeum (albiglutide)</li> <li>• Kazano (alogliptin / metformin)</li> <li>• Janumet/Janumet XR (sitagliptin / metformin)</li> <li>• Any other Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitor</li> </ul>	Y	N
<p>7. Has the patient had a trial and inadequate response with metformin?</p>	Y	N
<p>8. Will the patient be continuing therapy with at least one of the anti-hyperglycemic agents listed below? <b>(Please Circle)</b></p> <ul style="list-style-type: none"> <li>• Metformin</li> <li>• Actos (pioglitazone)</li> <li>• Insulin</li> <li>• Glimepiride</li> <li>• Glyburide</li> <li>• Glipizide</li> </ul>	Y	N
<p>9. Has the patient been on this therapy previously?</p>	Y	N
<p>10. What was the patient's hemoglobin A1c before starting therapy? <b>(Please Circle)</b></p> <ul style="list-style-type: none"> <li>• Less than 7.0%</li> <li>• Between 7.0%-8.0%</li> <li>• Greater than 8.0%</li> </ul> <p><i>Please provide documentation.</i></p>		
<p>11. What is the patient's hemoglobin A1c? <b>(Please Circle)</b> <i>HbA1c must be taken within the past 6 months.</i></p> <ul style="list-style-type: none"> <li>• Less than 7.0%</li> <li>• Between 7.0%-8.0%</li> <li>• Greater than 8.0%</li> </ul> <p><i>Please provide documentation.</i></p>		



12. Has the patient tried and had an inadequate response with any of the additional therapies listed below? **(Please Circle)**

- Sulfonylurea (e.g., glimepiride, glyburide or glipizide)
- Thiazolidinediones [e.g., Actos (pioglitazone) or Avandia (rosiglitazone)]
- Insulin

*Please provide documentation.*

Y	N
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***Please note, not all drugs/diagnoses are covered on all plans.***

Comments: \_\_\_\_\_

*Information given on this form is accurate as of this date.*

*Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.*

\_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Medical Staff – Name/Title**

**Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.**

**I understand that USDoctor’s use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**



**Contact Information:**

Telephone: (855)251.9116

Fax: (248)593.9575

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**PRIOR AUTHORIZATION FORM:  
COVER PAGE**

MEMBER INFORMATION			
First Name		Last Name	
Plan			
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name			
Quantity		ICD-10	
Directions		Duration of Therapy	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			
IgE: _____			
ESR: _____ CRP: _____ # Joints: _____ %BSA: _____			
Height: _____ Weight: _____ BMI: _____			
HA1C: _____ Hemoglobin: _____ Hematocrit: _____ T-Score: _____			
Dialysis: _____ Long Term Care Facility: _____ Self Injecting: _____			
Stimulation test: _____ / _____ Growth velocity: _____ #Chemotherapy cycles/month: _____			
Mini-Mental Status Test: _____ Baseline Free testosterone/Total testosterone: _____ / _____			
HCV RNA viral load: _____ Viral Genotype: _____ ALT: _____			
PHYSICIAN INFORMATION			
Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function  <input type="checkbox"/> Urgent <input type="checkbox"/> For Review	Pharmacy Fax	
The information contained in this facsimile message, including the attachments, may be privileged, may constitute inside information and is intended only for use of the addressee. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited and may be unlawful. If you have received this communication in error, please immediately notify me by replying to this message and destroy the original message.			