Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Sodium Glucose Cotransporter-2 (SGLT-2) Inhibitors Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Sodium Glucose Cotransporter-2 (SGLT-2) Inhibitors.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Provider Name: ______________________________ Provider NPI: ____________________________

Provider Address: ____

Provider Phone #: __________________________Provider Fax #: ___________________________

Please check the boxes that apply:

□Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5 – Diagnosis

Diagnosis of Type 2 Diabetes?
□No □ Yes

Current A1c%: ____________ A1c Date: ____________ Goal A1c%: ____________

6 – Clinical Criteria

Patients with A1c% < 7.5%:
□ Documented Trial of ≥ 90 days with metformin (unless contraindicated)
Dates of metformin therapy: ____

Patients with A1c% ≥ 7.5%:
□ Initiated therapy both metformin (unless contraindicated), plus a second agent (Sulfonylurea, DPP-IV, SGLT-2, GLP-1, TZD) [90-day trial is not required]

If contraindicated to metformin, please select from the following:
- □ eGFR below 45 mL/min/1.73m2 for initiation of therapy
- □ eGFR below 30 mL/min/1.73m2 for maintenance therapy
- □ Known hypersensitivity
- □ Acute or chronic metabolic acidosis including diabetic ketoacidosis

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.
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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**

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