Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
SGLT2 Inhibitors, SGLT2 Inhibitor Combinations (Metformin, DPP-4 Inhibitors)
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **SGLT2 Inhibitors, SGLT2 Inhibitor Combinations (Metformin, DPP-4 Inhibitors).** Please complete all sections, incomplete forms will delay processing. 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 all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

Medications:

• FARXIGA	• XIGDUO XR
• INVOKAMET, INVOKAMET XR	• GLYXAMBI
• INVOKANA	• QTERN
• SEGLUROMET	• STEGLUJAN
• STEGLATRO	

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?

□ Yes – please provide your provider referral number here: _____

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/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria (For Diabetes treatment indication):

1. Does the member have a diagnosis of type 2 diabetes mellitus?
   □ No □ Yes

2. Is the patient ≥18 years old?
   □ No □ Yes

3. Is the HbA1c within 2% above goal (as per ADA guidelines) within 90 days of the PA request (*Note: if A1c is >2% above goal, insulin therapy is recommended)*?
   □ No □ Yes

4. Has the member had an adequate trial (90 days) of BOTH of the following preferred oral medications: metformin and Jardiance at maximum tolerated dose unless resulting in a therapeutic failure, contraindication, or intolerance?
   □ No □ Yes

5. Does the member meet at least ONE of the following?
   a. Member has at least one of the following 3 qualifying conditions:
      - Atherosclerotic Cardiovascular Disease (ASCVD) [conditions include acute coronary syndromes (ACS), history of myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, ischemic stroke, transient ischemic attack (TIA), or symptomatic peripheral arterial disease (PAD)]
        □ No □ Yes
      - Chronic Kidney Disease
        i. GFR between 30 and 59 mL/min or urine albumin/creatinine ratio over 300 mg/g, AND
        ii. On maximally tolerated dose or patient has an allergy or intolerance* to ACE/ARB
        □ No □ Yes
      - Heart Failure
        □ No □ Yes
   b. **OR** member has had adequate trial (90 days) of ALL of the following more preferred medications for diabetes, unless allergy or intolerance:
      - Sulfonylurea
      - Pioglitazone (if BMI <35)
      - Tradjenta
      - Victoza[*PA]

      □ No □ Yes

Additional Criteria for Invokana & Invokamet/Invokamet XR:

1. Does the member have a history of diabetes-related lower limb amputation or diabetic foot ulceration?
   □ No □ Yes

<u>Clinical Criteria (For Heart Failure treatment indication - Farxiga and Xigduo XR only):</u>

1. Does the member have a diagnosis of heart failure with ejection fraction of 40% or less?
   □ No □ Yes

2. Is this medication being prescribed by or in consultation with Cardiology?
   □ No □ Yes

3. Is the member on maximally tolerated dose, or has an allergy or intolerance* to ACE/ARB and beta blocker?
   □ No □ Yes

4. Does the member have eGFR of at least 20 mL/min?
   □ No □ Yes

5. Has the member failed adequate trial (≥3 months), had intolerance to, or contraindication to Jardiance?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. If treating DM and no qualifying conditions, is there documented A1c lowering of at least 0.5% from initial or A1c now at goal?
   □ No □ Yes □ N/A – treating HF

*[PA]*This medication is also subject to PA review*

NOTES:
* Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment and do not require medication discontinuation

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**