Farxiga (dapagliflozin)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Type II diabetes for blood glucose control ☐ Heart Failure ☐ Type II diabetes with established cardiovascular disease and/or with additional cardiovascular risk ☐ Chronic kidney disease ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in a clinical trial? ☐ Yes ☐ No

Patient is required to use the authorized generic dapagliflozin.
Does patient have an absolute contraindication to dapagliflozin? ☐ Yes ☐ No Please submit documentation.

<u>For patient with Type II Diabetes only, answer the following</u>:

Is the patient's estimated glomerular filtration rate (GFR) below 25 mL/min/1.73 m2?* □ Yes □ No
***Please provide documentation.**

Is the patient on dialysis? □ Yes □ No

Is the patient already taking the requested medication? □ Yes □ No

Was the patient's hemoglobin A1C (HbA1c) 7.0% or greater prior to therapy (HbA1c must be taken within the past 6 months if the patient has not been on this treatment previously)?* □ Yes □ No
***Copy of HbA1c level required.**

Is the patient currently on metformin?* □ Yes □ No

Does the patient had an inadequate response or intolerance to metform? □ Yes □ No
****Please provide documentation***

Does the patient have at least one of the following contraindication to metformin? □ Yes □ No (Please Check one)
□ Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy

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For patient with Type II diabetes with established cardiovascular disease and/or risks, answer the following:

Is the patient 40 years of age or older? □ **Yes** □ **No**

Does patient have Type II diabetes? □ **Yes** □ **No**

Is patient's most recent HgbA1c level in the past 6months AT LEAST 6.5% and is LESS THAN 12.0%, prior to therapy (HbA1c must be taken within the past 6 months if the patient has not been on this treatment previously)? □ **Yes** □ **No** ***Please provide documentation***

Is the patient's eGFR 25ml/min/1.73 m2 or greater? □ **Yes** □ **No**

Does the patient have established cardiovascular disease as described as ischemic heart disease and/or cerebrovascular disease and/or peripheral arterial disease? □ **Yes** □ **No** ***Please provide documentation.***

Is the patient a 55 year old(or older) male with dyslipidemia, hypertension and/or who smokes 5 or more cigarettes/day? □ **Yes** □ **No**

Is the patient a 60 year old(or older) female with dyslipidemia, hypertension and/or who smokes 5 or more cigarettes/day? □ **Yes** □ **No**

For patient with heart failure with or without diabetes, answer the following:

Has patient ever had NYHA class II, III, or IV symptoms of heart failure? □ **Yes** □ **No** ***Please provide documentation***

Does patient have ejection fraction of 40% or less? □ **Yes** □ **No** ***Please provide documentation***

Does patient have ejection fraction of greater than 40% □ **Yes** □ **No** ***Please provide documentation.***

Does patient's body mass index(BMI) equal less than 50kg/m^2 ? □ **Yes** □ **No** ***Please provide documentation.***

Does patient have a NT-proBNP greater than 300pg/ml? □ **Yes** □ **No** ***Please provide documentation.***

For patients with A-fib, is the NT-proBNP greater than 600pg/ml? □ **Yes** □ **No** ***Please provide documentation.***

IF NT-proBNP not available, does patient have a BNP >100pg/ml? □ **Yes** □ **No** ***Please submit chart documentation.***

If NT-proBNP not available and patient has Atrial fibrillation (AF), does patient have a BNP >100pg/ml? □ **Yes** □ **No** ***Please submit chart documentation***

Does the patient have structural heart disease such as one or more of the following:? □ **Yes** □ **No** ***Please provide documentation from echocardiogram.***

□ **LA width >3.8cm**
□ **LA length >5.0 cm**
□ **LA area >20cm2**
□ **LA volume >55ml**
□ **LA volume index >29ml/m2**

Does patient have and eGFR less than 25ml/min/1.73m^2? □ **Yes** □ **No**

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Has patient had a heart translplant or complex congenital heart disease? □ Yes □ No

Does patient have severe <u>pulmonary disease</u> including severe COPD, requiring home oxygen therapy for their COPD, chronic nebulizer therapy or chronic oral steroid therapy for treatment of their severe COPD? □ Yes □ No
Please submit chart documentation.

Does patient have severe <u>pulmonary disease</u> including WHO group 1 primary pulmonary hypertension? □ Yes □ No
Please submit chart documentation.

Does patient have any other condition or diagnosis causing patient's heart failure symptoms such as? □ Yes □ No
Please submit chart documentation.
□ Anemia
□ hypothyroidism
□ Known infiltrative cardiomyopathy(e.g. amyloid sarcoid, lymphoma, endomyocardial fibrosis)
□ Active myocarditis
□ Constrictive pericarditis
□ Cardiac tamponade
□ Known genetic hypertrophic cardiomyopathy or obstructive hypertrophic cardiomyopathy
□ Arrhythmogenic right ventricular cardiomyopathy/dysplasia
□ Uncorrected primary valvular disease

<u>For patients with chronic kidney disease with or without diabetes, answer the following</u>:

Does patient have and estimated GFR(eGFR) that equals between 25-75ml/min/1.73m^2 (inclusive)? □ Yes □ No
Please provide documentation

Has patient been on an ACE inhibitor or ARB for at least one month? □ Yes □ No

Does patient have an absolute contraindication to the ACE inhibitor or ARB drug class? □ Yes □ No

Does patient have Type 1 diabetes? □ Yes □ No
Does patient have polycystic kidney disease? □ Yes □ No

Does patient have lupus nephritis? □ Yes □ No
Does patient have ANCA-associated vasculitis? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

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ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
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St. Paul, MN 55164-0811
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