

**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	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PHONE NUMBER:</b>	<b>DATE OF BIRTH:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:                      ZIP CODE:</b>
<b>PATIENT INSURANCE ID NUMBER:</b>	

**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](http://PRIMETHERAPEUTICS.COM/NOPP)**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** \_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** \_\_\_\_\_

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

MEDICATION OR MEDICAL DISPENSING INFORMATION			
<b>MEDICATION NAME:</b>			
<b>DOSE/STRENGTH:</b>	<b>FREQUENCY:</b>	<b>LENGTH OF THERAPY/REFILLS:</b>	<b>QUANTITY:</b>
<input type="checkbox"/> <b>NEW THERAPY</b> <input type="checkbox"/> <b>RENEWAL</b> <b>IF RENEWAL: DATE THERAPY INITIATED:</b> _____			
<b>DURATION OF THERAPY (SPECIFIC DATES):</b>			

*Continued on next page*



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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		
<input type="checkbox"/> <b>YES</b> (if yes, complete below) <input type="checkbox"/> <b>NO</b>		
<b>MEDICATION/THERAPY</b> (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Type II diabetes for blood glucose control <input type="checkbox"/> Heart Failure <input type="checkbox"/> Type II diabetes with established cardiovascular disease and/or with additional cardiovascular risk <input type="checkbox"/> Chronic kidney disease  <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s):		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<b>Is patient going to be using drug in a clinical trial?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Patient is required to use the authorized generic dapagliflozin.</b> <b>Does patient have an absolute contraindication to dapagliflozin?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		
<b><u>For patient with Type II Diabetes only, answer the following:</u></b> <b>Is the patient's estimated glomerular filtration rate (GFR) below 25 mL/min/1.73 m<sup>2</sup>?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation.</i>		
<b>Is the patient on dialysis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Is the patient already taking the requested medication?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>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)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Copy of HbA1c level required.</i>		
<b>Is the patient currently on metformin?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Does the patient had an inadequate response or intolerance to metform?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation</i>		
<b>Does the patient have at least one of the following contraindication to metformin?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(Please Check one)</b>		



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Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy

**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 6 months 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 49% or less?  Yes  No *\*Please provide documentation*

Does patient have ejection fraction of greater than 49%  Yes  No *\*Please provide documentation.*

Does patient's body mass index(BMI) equal less than 50kg/m<sup>2</sup> ?  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

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- LA length >5.0 cm
- LA area >20cm<sup>2</sup>
- LA volume >55ml
- LA volume index >29ml/m<sup>2</sup>

Does patient have and eGFR less than 25ml/min/1.73m<sup>2</sup>?  Yes  No

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

Does patient have severe pulmonary disease 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 pulmonary disease 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

**For patients with chronic kidney disease with or without diabetes, answer the following:**

Does patient have and estimated GFR(eGFR) that equals between 25-75ml/min/1.73m<sup>2</sup> (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?

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

**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  
P.O. Box 64811  
St. Paul, MN 55164-0811  
**Phone:** 877-228-7909