InvokametXR (canagliflozin/metformin ext rel)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

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:**
REQUESTOR (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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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

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 □ Type II diabetes with established cardiovascular disease □ Type II diabetes with diabetic nephropathy and albuminuria □ Other Diagnosis_____ICD-10 Code(s):_____	

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

Clinical information:

<u>If prescribing for Type II Diabetes, please answer the following:</u>

Is the patient's estimated glomerular filtration rate (GFR) below 30 mL/min/1.73 m2? □ Yes □ No
Please provide documentation.

Is the patient's most recent (pre-InvokametXR) HgbA1C obtained in the past 6 months 7% 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 *Please provide documentation*

Is the patient on dialysis? □ Yes □ No

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)
□ Estimated glomerular filtration rate (GFR) less than or equal to 30 mL/min/1.73 m2
□ Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy

<u>If prescribing for Type II diabetes with established cardiovascular disease, please answer the following</u>

Is patient 30 years or older? □ Yes □ No

Is the patient's most recent hemoglobin A1c level within the past 6 months equals 7.0 - 10.5%, inclusive 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.*

Does patient have symptomatic atherosclerotic cardiovascular disease? □ Yes □ No
Please select at least one of the following characterizations :
□ History of stroke

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

□ **Hospital admission for unstable angina**
□ **History of coronary revascularization procedure**
□ **History of peripheral revascularization procedure**
□ **History of amputation secondary to peripheral vascular disease**
□ **Patient is symptomatic with documented hemodynamically-significant carotid or peripheral vascular disease**

Is the patient 50years of age or older AND has 2 or more of the following risk factors? □ Yes □ No
Please select at least 2 of the following risk factors AND provide chart documentation:
□ **Duration of diabetes of 10 years or longer**
□ **Systolic blood pressure is greater than 140mmHg while receiving antihypertensive medication**
□ **Current daily cigarette smoker**
□ **Documented albuminuria**
□ **Documented HDL-cholesterol equaling less than 39mg/dL**
□ **Documented estimated glomerular filtration rate(GFR) is above 30mL/minute/1.73m^2**

<u>If prescribing for Type II diabetes with established cardiovascular disease, please answer the following</u>:
Is patient 30 years or older? □ Yes □ No

Is the patient's most recent hemoglobin A1c level within the past 6 months equals 6.5 - 12%, inclusive 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 estimated glomerular filtration rate (GFR) equal to 30 to less than 90 mL/min/1.73 m2? □ Yes □ No *Please provide documentation.*

Is patient currently receiving treatment with an ACE inhibitor or an ARB(angiotensin receptor blocker)? □ Yes □ No *Please provide documentation.*

Was the patient intolerant of past treatment with ACE inhibitors or ARBs? □ Yes □ No *Please provide documentation.*

Does patient have nondiabetic renal disease? □ Yes □ No

Does patient's renal disease require immunosuppressant, chronic dialysis or renal transplant? □ 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.

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.

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

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

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