Inpefa (sotagliflozin)
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:**
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**		**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:**
☐ Chronic kidney disease(CKD) ☐ Congestive heart failure(CHF) ☐ 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

For all diagnosis, please answer the following:

Is patient taking an SGLT2 product such as: Jardiance(empagliflozin), Glyxambi(linagliptin/empagliflozin), Invokana/(canagliflozin), Farxiga(dapagliflozin), XigduoXR(dapagliflozin/metformin), Invokamet/InvokametXR(canagliflozin/metformin), Steglatro(ertugliflozin), Synjardy/SynjardyXR(empagliflozin/metformin), Segluromet(ertugliflozin/metformin), Steglujan(ertugliflozin/sitagliptin), Qtern(dapagliflozin/saxagliptan) in combination with Inpefa(sotagliflozin)?

Will patient discontinue the SGLT2 they are currently taking prior to starting Inpefa(sotagliflozin)?

Does patient have an absolute contraindication to an SGLT2?

For diagnosis of chronic kidney disease, please answer the following:

Does patient have Type II diabetes with a HgA1c of ≥7%? ☐ Yes ☐ No *Please provide lab report.*

Does patient have chronic kidney disease with an EGFR ≥25 and ≤60mL/min/1.73m^2? ☐ Yes ☐ No *Please provide lab report.*

Does patient have at least one major cardiovascular risk-factor? ☐ Yes ☐ No *Please provide chart notes.*

- **Diabetes mellitus, type 1 or 2**
- **Age 65 years or older**
- **MI or non-hemorrhagic stroke (TIAs don't qualify) in the past 6 months**
- **Current daily cigarette smoker**
- **History of more than one MI**
- **History of more than one non-hemorrhagic stroke (TIAs don't qualify)**
- **History of one MI plus one non-hemorrhagic stroke (TIAs don't qualify)**
- **History of one MI plus history of symptomatic peripheral arterial disease as defined above**
- **History of one non-hemorrhagic stroke (TIAs don't qualify) plus history of symptomatic peripheral arterial disease as defined above**

If patient is 55 years of age or older without a major cardiovascular risk, does patient have at least two minor cardiovascular risk factors? ☐ Yes ☐ No *Please provide chart notes.*

- **History of non-MI related coronary revascularization**

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- **Residual coronary artery disease with >40% stenosis in at least 2 large vessels**
- **Metabolic syndrome (as defined by Alberti et al., Circulation, 2009; 120:1640-1645, Tables 1 & 2)**
- **Most recent HDL-C < 40 mg/dL (men) and < 50 mg/dL (women), in the absence of metabolic syndrome or in the presence of metabolic syndrome when 3 of its four non-HDL criteria are met (as per Alberti et al., 2009)**
- **Most recent hsCRP (high-sensitivity C-reactive protein) > 2.0 mg/L**
- **Most recent LDL-C > 130 mg/dL or non-HDL-C > 160 mg/dL**
- **Most recent fasting LDL-C > 70 mg/dL or non-HDL-C > 100mg/dL after > 2 weeks stable lipid lowering therapy**
- **Most recent fasting triglycerides < 400 mg/dL**

Has the patient tried at least 2 different SGLT2 products for chronic kidney disease such as: Jardiance(empagliflozin), Invokana/(canagliflozin), Farxiga(dapagliflozin), XigduoXR(dapagliflozin/metformin), Invokamet/InvokametXR(canagliflozin/metformin), Synjardy/SynjardyXR(empagliflozin/metformin),)? *_NOTE_: *patient cannot take 2 products that contain the same main SGLT2 ingredient, e.g. Jardiance(empagliflozin) and Synjardy(empagliflozin/metformin)*- □ Yes □ No *Please provide chart notes.*

Is the SGLT2 medication not working? □ Yes □ No *Please provide chart notes.*

For diagnosis of congestive heart failure, please answer the following:
Does patient have Type II diabetes with a HgA1c of ≥6.4 AND ≤8.5%? □ Yes □ No *Please provide lab report.*

Has patient had a diagnosis of congestive heart failure for greater than 3 months? □ Yes □ No *Please provide chart notes.*

Has patient been admitted to the hospital or has had an urgent heart failure visit for worsening heart failure in the last 30 days? □ Yes □ No *Please provide chart notes.*

Has patient been on a loop diuretic for at least 30 days or greater? □ Yes □ No *Please provide chart notes.*

Does the patient have a BNP ≥150pg/mL or a N-BNP ≥600pg/mL OR a BNP >450pg/mL or N-BNP >1800pg/mL if the patient has atrial-fibrillation? □ Yes □ No *Please provide chart notes.*

If patient has a Left Ventricular Ejection Fraction(LVEF) <40%, is the patient on beta-blockers and renin-angiotensin-aldosterone system(RAAS) inhibitors? □ Yes □ No *Please provide chart notes.*

Are beta-blockers contraindicated in this patient? □ Yes □ No *Please provide chart notes.*
Are renin-angiotensin-aldosterone system(RAAS) inhibitors contraindicated in this patient? □ Yes □ No *Please provide chart notes.*

Does patient have worsening heart failure attributed to other causes such as pulmonary embolism, stroke, and/or myocardial infarction(MI)? □ Yes □ No *Please provide chart notes.*

Does patient have uncorrected primary valve disease? □ Yes □ No *Please provide chart notes.*

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Does patient have acute decompensated heart failure? □ Yes □ No *Please provide chart notes.*

Does patient have a cardiomyopathy based on any other inflitrative disease(s), such as patient does not have significant mitral valve regurgitation causing the heart failure, any dilated cardiomyopathy, infiltrative cardiomyopathy, drug induced cardiomyopathy, or viral myocarditis? □ Yes □ No *Please provide chart notes.*

Does patient have significant pulmonary disease contributing substantially to the patient's dyspnea such as severe COPD requiring home oxygen therapy for their COPD, chronic nebulizer therapy or chronic oral steroid therapy for treatment of their severe COPD, or primary pulmonary hypertension? □ Yes □ No *Please provide chart notes.*

Does patient have severe kidney disease with an eGFR <30mL/min/1.72m^2? □ Yes □ No *Please provide chart notes.*

Does patient require dialysis? □ Yes □ No

Has patient had a 3-month trial with Jardiance(empagliflozin) AND a 3-month trial with Farxiga(dapagliflozin)? □ Yes □ No *Please provide chart notes.*

Does patient have an absolute contraindication to Jardiance(empagliflozin) and Farxiga(dapagliflozin)? □ Yes □ No *Please provide chart notes.*

Is the SGLT2 medication not working? □ Yes □ No *Please provide chart notes.*

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.

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