

Jardiance (empagliflozin)
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: |
| <input type="checkbox"/> NEW THERAPY <input type="checkbox"/> 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? | | |
|---|--|---|
| <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO | | |
| MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): | DURATION OF THERAPY (SPECIFY DATES): | RESPONSE/REASON FOR FAILURE/ALLERGY: |
| 2. LIST DIAGNOSES: | | ICD-10: |
| <input type="checkbox"/> Type II diabetes <input type="checkbox"/> Type II diabetes with established cardiovascular disease <input type="checkbox"/> Congestive heart failure <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. | | |
| Is patient going to be using drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <u>If prescribing for Type II Diabetes, please answer the following:</u> Is the patient's estimated glomerular filtration rate (eGFR) below 20 mL/min/1.73 m2? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide documentation.</i> | | |
| Is the patient's most recent (pre-Jardiance) HgbA1C obtained in the past 6 months or prior to starting Jardiance(empagliflozin) 7% or greater? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide documentation.</i> | | |
| Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Is the patient currently on metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Did the patient have an inadequate response or intolerance to metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation</i> | | |
| Does the patient have at least one of the following contraindications to metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please Check one) | | |
| <input type="checkbox"/> Estimated glomerular filtration rate (eGFR) less than or equal to 20 mL/min/1.73 m2 <input type="checkbox"/> Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy | | |
| Is the patient's most recent hemoglobin A1c level within the past 6months or prior to starting Jardiance(empagliflozin) 7.0-10%, inclusive? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide documentation.</i> | | |
| Does the patient's body mass index(BMI) exceed 45kg/m ² ? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |



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Is the patient's estimated glomerular filtration rate (eGFR) 20 mL/min/1.73 m² or above? Yes No

Please provide documentation.

Is the patient's medical history positive for at least one of the following? Yes No

Please check at least one of the following:

- MI or Stroke
- Imaging shows single-vessel or multi-vessel coronary artery disease
- Previous coronary revascularization procedure
- Positive cardiac stress test
- Hospital admission for unstable angina
- Occlusive peripheral arterial disease (defined as limb revascularization procedure, limb or foot amputation due to circulatory insufficiency, imaging or non-invasive study showing evidence of more than 50% stenosis in an artery, and/or ankle: brachial index equaling less than 0.9 in an ankle.)

For diagnosis of congestive heart failure, please answer the following:

Does patient have an ejection fraction(EF) equaling 40% or less? Yes No *Please provide documentation.*

Does patient have an ejection fraction(EF) greater than 40%? *Please provide documentation.*

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

Does patient's body mass index(BMI) equal less than 45kg/m² ? 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 900pg/ml? Yes No *Please provide documentation.*

IF NT-proBNP not available, does patient have a BNP >100pg/ml without kidney failure? Yes No *Please submit chart documentation.*

If NT-proBNP not available and patient has kidney failure, does patient have a BNP>200pg/ml? Yes No *Please submit chart documentation.*

If NT-proBNP not available and patient has Atrial fibrillation (AF), does patient have a BNP >150pg/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 >4.0cm
- LA length >5.0 cm

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- LA area >20cm²
- LA volume >55ml
- LA volume index >34ml/m²

Does the patient has left ventricular hypertrophy defined by at least one of the following? Yes No *Please provide documentation from echocardiogram.*

- Septal thickness or posterior wall thickness >1.1 cm
- LV mass index(LVMI) >115g/m² for males and >95 g/m² for females
- E/e' (mean septal and lateral) >13
- e' (mean septal and lateral) <9cm/s

Has patient been hospitalized in the past 12 months before starting Jardiance(empagliflozin)? Yes No *Please provide documentation.*

Is patient on a stable dose of a diuretic? Yes No *Please provide documentation.*

Has patient had a myocardial infarction, coronary bypass graft surgery or other major cardiovascular surgery, stroke or TIA in the past 90 days of starting Jardiance? Yes No *Please provide documentation.*

Has patient had a heart transplant? Yes No

Does patient have acute decompensated heart failure? 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 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 patient has significant mitral valve regurgitation causing the heart failure, any dilated cardiomyopathy, infiltrative cardiomyopathy, or viral myocarditis? Yes No *Please submit chart documentation.*

Does patient have and eGFR less than 20ml/min/1.73m²? Yes No

Does patient require dialysis? Yes No

Is patient's heart failure related to any of the following? Yes No *Please check at least one of the following:*

- infiltrative disease
- accumulation disease
- muscular dystrophy
- hypertrophic obstructive cardiomyopathy
- known pericardial restriction

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- valvular disease expected to lead to surgery
- atrial fib/flutter with a resting heart rate greater than 110 bpm

If prescribing for the diagnosis of chronic kidney disease(CKD), please answer the following:

Has the patient had an estimated glomerular filtration rate(eGFR) ≥ 20 to < 45 mL/min/1.73m² for 3 or more months? Yes No *Please submit chart documentation.*

Has the patient had an estimated glomerular filtration rate(eGFR) an eGFR ≥ 45 to < 90 mL/min/1.73m² for 3 or more months? Yes No *Please submit chart documentation.*

Has the patient had a urinary albumin:creatinine ratio ≥ 200 mg/g (or protein:creatinine ratio ≥ 300 mg/g) for 3 or months? Yes No *Please submit chart documentation.*

Is patient taking either a renin-angiotensin-converting enzyme inhibitor(ACEi) or or an angiotensin II receptor blocker(ARB)? Yes No *Please submit chart documentation.*

Is an ACEi or ARB contraindicated? Yes No *Please submit chart documentation.*

Does patient have Typell diabetes AND prior atherosclerotic cardiovascular disease with an cGFR > 60 ml/min/1.73m²? Yes No *Please submit chart documentation.*

Is patient receiving both an ACEi and an ARB at the same time? Yes No

Is patient receiving maintenance dialysis? Yes No

Has the patient received a kidney transplant? Yes No

Does patient have polycystic kidney disease? Yes No

Does patient have Type1 diabetes? 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.

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

Phone: 877-228-7909