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:**
☐ **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** ☐ **Type II diabetes with established cardiovascular disease** ☐ **Congestive heart failure** ☐ **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 combination with a clinical trial? ☐ **Yes** ☐ **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? □ **Yes** □ **No**
Please provide documentation.

Is the patient's most recent (pre-Jardiance) HgbA1C obtained in the past 6 months or prior to starting Jardiance(empagliflozin) 7% or greater? □ **Yes** □ **No** ***Please provide documentation.***

Is the patient on dialysis? □ **Yes** □ **No**

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

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

Does the patient have at least one of the following contraindications to metformin? □ **Yes** □ **No**
(Please Check one)
□ **Estimated glomerular filtration rate (eGFR) less than or equal to 20 mL/min/1.73 m2**
□ **Advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy**

<u>For patient with Type 2 DM with established cardiovascular disease</u>
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**

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

□ **Positive cardiac stress test**
□ **Hospital admission for unstable angina**
□ **Occulsive 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 49% or less? □ Yes □ No *Please provide documentation.*

Does patient have an ejection fraction(EF) greater than 49%? *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/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 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**
□ **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**

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□ **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.*

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/1.73m^2? □ 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**
□ **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.*

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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.***

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