Onglyza (saxagliptin) 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.

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

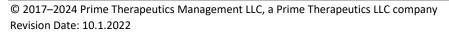
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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 📃 NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
 Type 1 diabetes Type 2 diabetes Other Diagnosis:	ICD-10 Code(s):			
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.				
Is the patient 18 years of age or older? □ Yes □ No Is the patient already taking the requested medication? □ Yes □ No Is the patient's HbA1c 7% or greater? □ Yes □ No No HbA1c must be taken within the past 6 months. Copy of HbA1c level rquired. Was the patient's most recent HbA1c level, PRIOR to STARTING the requested medication, 7.0% or greater?* □ Yes □ No *Copy of HbA1c level rquired. Is the patient currently on metformin?* □ Yes □ No No Does the patient had an inadequate response or intolerance to metform? *Please provide documentation Does the patient have at least one of the following contraindication to metformin? (Please Circle)				
 Estimated glomerular filtration rate (GFR) less than or equal to 45 mL/min/1.73 m2 advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy 				
Is the patient currently taking one of the Adlyxin (lixisenatide) Glyxambi (linagliptin/empagliflozi Byetta, Bydureon (exenatide) Janumet/Janumet XR (sitagliptin a Tradjenta (linagliptin) Nesina (alogliptin) Oseni (alogliptin-pioglitazone) Trulicity (dulaglutide) Victoza (liraglutide) Victoza (liraglutide) Januvia (sitigliptin) Jentadueto (linagliptin and metfo Kombiglyze XR (saxagliptin and m	in) and metformin) rmin) retformin)			



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Will the drug be discontinued?

Yes
No

- Adlyxin (lixisenatide)
- Glyxambi (linagliptin/empagliflozin)
- Byetta, Bydureon (exenatide)
- Janumet/Janumet XR (sitagliptin and metformin)
- Tradjenta (linagliptin)
- Nesina (alogliptin)
- Oseni (alogliptin-pioglitazone)
- Trulicity (dulaglutide)
- Victoza (liraglutide)
- Ozempic (semaglutide)
- Januvia (sitagliptin)
- Jentadueto (linagliptin and metformin)
- Kombiglyze XR (saxagliptin and metformin)
- Kazano (alogliptin and metformin)

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:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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

