AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – SGLT2 Inhibitors and Combinations

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

7. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
8. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other: _____

Clinical Information

Initial Requests for SGLT 2 Inhibitors and Combinations for both preferred and non-preferred products:

1. Does the beneficiary have a diagnosis of heart failure? Yes___ No___
2. Does the beneficiary have a diagnosis of Type 2 Diabetes? Yes___ No___
3. Has the beneficiary had a trial and failure or insufficient response to metformin therapy or other metformin containing products? Yes___ No___
4. Has the beneficiary had a contraindication or adverse event to metformin? Yes___ No___

List: _____

5. Does the beneficiary have established ASCVD, heart failure, or Chronic Kidney Disease? Yes___ No___
6. Is the beneficiary considered high-risk for ASCVD as defined as ≥ 55 years of age with ≥ 2 additional risk factors (e.g., smoking, obesity, hypertension, dyslipidemia, or albuminuria)? Yes___ No___

For non-preferred products: (in addition to questions 1-6)

7. Has the beneficiary tried and failed or experienced an insufficient response to at least two preferred products or have a clinical reason that preferred products cannot be tried? Yes___ No___

List: _____

Continuation Requests for SGLT 2 Inhibitors and Combinations for both preferred and non-preferred products:

1. Has the beneficiary improved while on this medication? Yes___ No___ **(Medical Documentation should be attached to this request)**
2. Are individual clinical goals that were set by the provider being met? Yes___ No___
3. Is the beneficiary continuing to make adequate progress towards treatment goals? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406