Farxiga® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

<table>
<thead>
<tr>
<th>Member Information (required)</th>
<th>Provider Information (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name:</td>
<td>Provider Name:</td>
</tr>
<tr>
<td>Insurance ID#:</td>
<td>NPI#:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Specialty:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Office Phone:</td>
</tr>
<tr>
<td>City:</td>
<td>Office Fax:</td>
</tr>
<tr>
<td>State:</td>
<td>Office Street Address:</td>
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<tr>
<td>Zip:</td>
<td>City:</td>
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<tr>
<td>Phone:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>Zip:</td>
</tr>
</tbody>
</table>

**Medication Information (required)**

<table>
<thead>
<tr>
<th>Medication Name:</th>
<th>Strength:</th>
<th>Dosage Form:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

- Check if requesting brand
- Check if request is for continuation of therapy

**Clinical Information (required)**

**Select the diagnosis below:**
- Type 2 diabetes mellitus
- Other diagnosis: ___________________________ ICD-10 Code(s): ___________________________

**Select the medications the patient has a failure, contraindication, or intolerance to:**
- Invokamet
- Invokamet XR
- Invokana
- Jardiance
- Metformin
- Metformin extended-release (ER) (generic Fortamet)
- Metformin ER (generic Glucophage XR)
- Metformin ER (generic Glumetza)
- Riomet
- Synjardy
- Synjardy XR

**Quantity limit requests:**
What is the quantity requested per DAY? ______

**What is the reason for exceeding the plan limitations?**
- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: ___________________________
- Other: ___________________________

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: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.