Invokamet® & Invokamet® XR Prior Authorization Request Form (Page 1 of 2)

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<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#: Speciality:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Office Phone:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Office Fax:</td>
</tr>
<tr>
<td>City: State: Zip:</td>
<td>Office Street Address:</td>
</tr>
<tr>
<td>Phone:</td>
<td>City: State: Zip:</td>
</tr>
</tbody>
</table>

Medication Information (required)

Medication Name: Strength: Dosage Form:

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

Directions for Use:

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:
- Alogliptin-metformin
- Glipizide-metformin
- Glyburide-metformin
- Janumet
- Janumet XR
- Jentadueto
- Jentadueto XR
- Kombiglyze XR
- Metformin
- Metformin and Farxiga (individual agents used in combination)
- Metformin and Jardiance (individual agents used in combination)
- Metformin extended-release (ER) (generic Fortamet)
- Metformin ER (generic Glucophage XR)
- Metformin ER (generic Glumetza)
- Metformin ER (generic Glucophage XR) and Farxiga (individual agents used in combination)
- Metformin ER (generic Glucophage XR) and Jardiance (individual agents used in combination)
- Metformin ER (generic Glumetza) and Jardiance (individual agents used in combination)
- Pioglitazone
- Pioglitazone-glimepiride
- Pioglitazone-metformin
- Repaglinide-metformin
- Riomet and Farxiga (individual agents used in combination)
- Riomet and Jardiance (individual agents used in combination)
- Synjardy
- Synjardy XR
- Xigduo XR

<Continued on next page>
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.