OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Qtern® & Steglujan™ Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ 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:

- ❑ Alogliptin
- ❑ Alogliptin-metformin
- ❑ Glyxambi
- ❑ Invokamet
- ❑ Invokamet XR
- ❑ Janumet
- ❑ Janumet XR
- ❑ Januvia
- ❑ Jentadueto
- ❑ Jentadueto XR
- ❑ Kazano
- ❑ Kombiglyze XR
- ❑ Metformin
- ❑ Metformin extended-release (ER)
- ❑ Onglyza
- ❑ Riomet
- ❑ Synjardy
- ❑ Synjardy XR
- ❑ Xigduo XR

Does the patient have a failure, contraindication, or intolerance to a **Dipeptidyl peptidase-4 (DPP-4) inhibitor** (Januvia, Nesina, Onglyza, or Tradjenta) ***used in combination*** with a **Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor** (Farxiga, Invokana, or Jardiance)? ❑ **Yes** ❑ **No**

If YES, please indicate ALL specific combinations: _____

_____

_____

_____

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: _____

Qtern® & Steglujan™ Prior Authorization Request Form (Page 2 of 2)

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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.