# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

## Non-Preferred Sodium-glucose Cotransporter-2 Inhibitor (SGLT2) Drugs

**Drug Requested:** (Select one from below)

| | |
|---|---|
| ❑ **Brenzavvy™** (bexafliflozin) | ❑ **Invokana®** (canagliflozin) |
| ❑ **Invokamet® /XR** (canagliflozin/metformin/ER) | ❑ **Qtern®** (dapagliflozin/saxagliptin) |
| ❑ **Steglatro®** (ertugliflozin) | ❑ **Steglujan®** ertugliflozin/sitagliptin) |
| ❑ **Segluromet®** (ertugliflozin/metformin) | |

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member AvMed #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**DEA OR NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength**: _____

**Dosing Schedule**: _____ **Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Weight:** _____ **Date:** _____

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**(Continued on next page)**

- ❑ Member must meet **BOTH** of the following:
  - ❑ Member has tried and failed at least **90 days** of therapy with **ONE** of the following:
    - ❑ Farxiga®
    - ❑ Xigduo®
  - ❑ Member has tried and failed at least **90 days** of therapy with **ONE** of the following:
    - ❑ Jardiance®
    - ❑ Synjardy®/Synjardy® XR
    - ❑ Glyxambi®
    - ❑ Trijardy® XR

***Not all drugs may be covered under every Plan.***

***If a drug is non-formulary on a Plan, documentation of medical necessity will be required.***

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

*****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by the Pharmacy and Therapeutics Committee**: ~~5/16/2013;~~ **9/21/2023**
**REVISED/UPDATED:** ~~9/30/2013; 4/7/2014; 8/6/2014; 9/26/2014; 10/8/2014; 10/16/14; 10/30/2014; 1/15/15; 10/15/2015; 10/23/2015; 12/22/20215; 12/19/2016; 3/6/2017; 3/27/17; 3/28/2017; 5/4/2017; 8/17/2017; 3/1/2018; 6/8/2018; (REFORMATTED) 3/25/2019; 8/12/2019; 6/4/2020; 8/31/2020; 9/15/2022;~~ **10/17/2023**;