

SENTARA HEALTH PLANS

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 **1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization may be delayed.

Drug Requested: Inpefa™ (sotagliflozin)

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

Member Name: _____

Member Sentara #: _____ 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: _____

Quantity Limit: 1 tablet per day

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.

- Member is 18 years of age or older
- Medication will **NOT** be used in combination with another SGLT2 inhibitor
- Medication will **NOT** be used for glycemic control of type 1 diabetes mellitus

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- ❑ Member must meet **ONE** of the following:
 - ❑ Member is using for the treatment of New York Heart Association (NYHA) class II, III or IV heart failure symptoms **AND** has had trial and failure or intolerance to **BOTH** of the following (**verified by chart notes and/or pharmacy paid claims**):
 - ❑ Farxiga[®]
 - ❑ Jardiance[®]
 - ❑ Member has a diagnosis of Type 2 diabetes **AND** chronic kidney disease and meets **BOTH** of the following:
 - ❑ Provider attests member has one or more cardiovascular risk factor(s)
 - ❑ Member has had trial and failure or intolerance to Farxiga[®] (**verified by chart notes and/or pharmacy paid claims**)

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.