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.**

Dipeptidyl peptidase 4 (DPP4) Inhibitors

Drug Requested: (Select one below)

❑ **alogliptin** (Nesina® ABA)	❑ **Nesina®** (alogliptin)
❑ **alogliptin-pioglitazone** (Oseni® ABA)	❑ **Oseni®** (alogliptin and pioglitazone)
❑ **alogliptin-metformin** (Kazano® ABA)	❑ **saxagliptin** (Onglyza®)
❑ **Kazano®** (metformin and alogliptin)	❑ **saxagliptin-metformin ER** (Kombiglyze® XR)

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start 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.

Authorization Length: 12 months

(Continued on next page)

❑ **For alogliptin, alogliptin-pioglitazone, Nesina®, Oseni®, or saxagliptin**

- ❑ Member has tried and failed **90 days** of therapy with generic sitagliptin phosphate (Januvia)

AND

- ❑ Member has tried and failed **90 days** of therapy with Tradjenta®

❑ **For Kazano®, saxagliptin-metformin ER, or alogliptin-metformin**

- ❑ Member has tried and failed **90 days** of therapy with generic sitagliptin phosphate-metformin (Janumet) **OR** generic sitagliptin phosphate-metformin extended release (Janumet XR)

AND

- ❑ Member has tried and failed **90 days** of therapy with Jentadueto®

***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:** 10/15/2009
REVISED/UPDATED/REFORMATTED: ~~12/28/2015; 12/22/2016; 8/15/2017; 6/18/2018; 6/19/2019; 6/4/2020; 10/23/2023; 1/22/2024; 7/28/2026;~~ **10/16/2026**