SENTARA COMMUNITY PLAN
(MEDICAID)

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 the information provided is not complete, correct, or legible, the authorization process can 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, if applicable:** _____

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)**

*****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 Pharmacy and Therapeutics Committee**: 9/21/2023
REVISED/UPDATED/REFORMATTED: ~~9/12/2023; 10/17/2023; 12/13/2023,~~ **01/29/24**