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

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:
    - ❑ dapagliflozin (generic Farxiga®)
    - ❑ dapagliflozin/metformin (generic Xigduo® XR)
  - ❑ 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/REFORMATTED: ~~3/6/2017; 3/27/17; 3/28/2017; 5/4/2017; 8/17/2017; 3/1/2018; 6/8/2018; 3/25/2019; 8/12/2019; 6/4/2020; 8/31/2020; 9/15/2022; 10/17/2023; 11/20/2023;~~ **6/29/2026**