

Onglyza / Kombiglyze XR / Tradjenta / Jentadueto

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION

Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW or a CONTINUATION of THERAPY ? If so, start date: _____

Is this patient currently hospitalized? Yes No

Is the patient residing in a LTC facility? Yes No

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: Zip:
Phone: Fax:	NPI #:	Specialty:

Office Contact Name / Fax Attention to:

Medication to be Administered: Physician's Office Patient's Home LTC Facility Other

SECTION C - MEDICATION INFORMATION

Medication:	Strength:
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Directions for use:

Diagnosis (Please be specific & provide as much information as possible):	ICD-10 Code:
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Does the patient have a diagnosis of type 2 diabetes mellitus? YES NO

Has the patient tried and failed any of the following? (check any that apply)

- Metformin/metformin ER (eg, Glucophage, Glucophage XR)
- Sulfonylurea [eg, Amaryl (glimepiride), Diabeta (glyburide), Glucotrol (glipizide)]
- Thiazolidinedione (TZD) [eg, Actos (pioglitazone), Avandia (rosiglitazone)]
- Insulin [eg, Humalog, Humulin, Novolin, Novolog, Lantus]
- Byetta (exenatide)

For any that are checked please provide dates of therapy and reason for discontinuation:

Physician Signature: _____ **Date:** _____

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