UnitedHealthcare Community Plan

SGLT-2 Inhibitors
(Invokana, Farxiga, Jardiance, Invokamet, Xigduo XR, Synjardy)
PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
Allow at least 24 hours for review.

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? □ 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:				

Section C - Medical Information	
Medication:	**Strength:**
Dispense as Written: □ **Yes** □ **No**	
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ **Yes** □ **No**	**If yes, what is this member's due date?** _______________

Section D – Clinical Information

- Has the patient used metformin at a minimum dose of 1500mg daily for 90 days? □ Yes □ No
(if yes, complete below table with all medication information)

Requests for XigduoXR/Farxiga:

- Has the patient used any of the following? □ Yes □No (if yes, complete below table with medication information)

☐ Invokana ☐ Invokamet ☐ Invokamet XR ☐ Jardiance ☐Synjardy ☐Synjardy XR

Section E – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: ____ **Date:** __________________

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