DPP-4 INHIBITORS AND COMBINATIONS
STEP THERAPY REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient stable on the requested agent ☐ Yes ☐ No
2. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
3. Will the patient be using the requested agent in combination with another DPP-4 inhibitor/combination agent for the requested indication? ☐ Yes ☐ No
4. Will the patient be using the requested agent in combination with a GLP-1 agent? ☐ Yes ☐ No
5. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? ☐ Yes ☐ No
   If yes, is there support for therapy with a higher dose for the requested indication? ☐ Yes ☐ No
   If yes, please provide supporting information: _____
   _____
   If no, is there support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If yes, please provide supporting information: _____
   _____
6. Does the patient have an intolerance or hypersensitivity to sitagliptin that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please explain intolerance/hypersensitivity: _____
   _____
7. Does the patient have an FDA labeled contraindication to sitagliptin that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: _____
   _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

Preferred Agents	Non-Preferred Agents
Januvia (sitagliptin) Janumet (sitagliptin/metformin) Janumet XR (sitagliptin/metformin extended-release)	Alogliptin Alogliptin/metformin Alogliptin/pioglitazone Jentadueto (linagliptin/metformin) Jentadueto XR (linagliptin/metformin ER) Kazano (alogliptin/metformin) Kombiglyze XR (saxagliptin/metformin ER) Nesina (alogliptin) Onglyza (saxagliptin) Oseni (alogliptin/pioglitazone) Tradjenta (linagliptin) Zituvimet (sitagliptin free base/metformin) Zituvimet XR (sitagliptin free base/metformin) Zituvio (sitagliptin)

8. Has the patient tried and had an inadequate response to a preferred DPP-4 inhibitor agent? ..... ☐ Yes ☐ No
   If yes, please specify agent tried: _____
9. Was a preferred DPP-4 inhibitor discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ..... ☐ Yes ☐ No
   If yes, please specify agent tried: _____
10. Is a preferred DPP-4 inhibitor expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? ..... ☐ Yes ☐ No
11. Is a preferred DPP-4 inhibitor not in the best interest of the patient based on medical necessity? ..... ☐ Yes ☐ No
12. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a preferred DPP-4 inhibitor and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ..... ☐ Yes ☐ No
    If yes, please specify prescription drug: _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
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