DPP-4 INHIBITORS AND COMBINATIONS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

ALL REQUESTS

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____

Has the patient been treated with the requested agent within the past 90 days? ..... ☐ Yes ☐ No

If yes: Was the treatment with samples?..... ☐ Yes ☐ No

Is the patient at risk if therapy is changed?..... ☐ Yes ☐ No

Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____

_____

_____

_____

Please continue to the next page.

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

Will the patient be using the requested agent in combination with another DPP-4 inhibitor/combination agent (e.g., Alogliptin, Alogliptin/metformin, Alogliptin/pioglitazone, Januvia, Janumet, Janumet XR, Jentadueto, Jentadueto XR, Kazano, Kombiglyze XR, Nesina, Onglyza, Oseni, Tradjenta, Zituvio, Zituvimet, Zituvimet XR) for the requested indication? ☐ Yes ☐ No

Will the patient be using the requested agent in combination with a GLP-1 or GLP-1/GIP receptor agonist (e.g., Saxenda, Wegovy, Zepbound, Adlyxin, Bydureon, Byetta, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza)? ☐ Yes ☐ No

Does the patient's medication history include use of an agent containing metformin or insulin? ☐ Yes ☐ No

If yes: was metformin or insulin use in the past 90 days? ☐ Yes ☐ No

If no: does the patient have an intolerance or hypersensitivity to metformin, or insulin? ☐ Yes ☐ No

If no: does the patient have an FDA labeled contraindication to both metformin and insulin? ☐ Yes ☐ No

If currently treated with the requested medication: Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? ☐ Yes ☐ No

For Januvia, Janumet, or Janumet XR request:

Is the patient switching to the requested agent and the patient's medication history includes use of a non-preferred DPP-4 inhibitor agent in the past 90 days? Non-preferred DPP-4 inhibitors are Jentadueto, Jentadueto XR, Kazano, Kombiglyze XR, Nesina, Onglyza, Oseni, and Tradjenta. ☐ Yes ☐ No

For all other requests except Januvia, Janumet, or Janumet XR:

Does the patient's medication history include use of Januvia, Janumet, or Janumet XR? Please note, Januvia, Janumet, and Janumet XR are the preferred DPP-4 inhibitor agents. ☐ Yes ☐ No

If no: does the patient have a documented intolerance or hypersensitivity to sitagliptin? ☐ Yes ☐ No

If no: does the patient have an FDA labeled contraindication to sitagliptin that is not expected to occur with the requested agent? ☐ Yes ☐ No

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

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

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183