Prior Authorization Form
Hypoglycemic Medications

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Magellan Rx MANAGEMENT℠

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: – –

Member's Address:

City:

State:

ZIP:

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: – –

Office Fax Number: – –

CLINICAL CRITERIA

1. What medication is being requested? ____
2. What is the member's diagnosis and medical condition? (Check all that apply.)
   - ☐ Diabetes mellitus type 2
   - ☐ End stage renal disease
   - ☐ Chronic kidney insufficiency
   - ☐ Receiving hemodialysis
   - ☐ Heart failure (NYHA class II-IV) with reduced ejection fraction
   - ☐ Moderate to severe renal impairment
   - ☐ Congestive heart failure
   - ☐ Other: ______________________________________
3. Has the member failed to achieve adequate glycemic control with metformin, metformin ER, glipizide/metformin, glyburide/metformin, or pioglitazone/metformin?
   - ☐ Yes ☐ No

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | | **Member's First Name:** | | | | | | | | | | | |

4. Is the member currently taking any of the medications listed below? (Check all that apply.)
   - ☐ Diuretics (e.g., furosemide, amiloride)
   - ☐ Angiotensin II receptor blockers/ARB (e.g., candesartan)
   - ☐ Angiotensin converting enzyme inhibitors/ACEI (e.g., lisinopril)
   - ☐ NSAID (e.g., ibuprofen, celecoxib)
5. What is the member's estimated glomerular filtration rate (eGFR) and what is the date this measurement was taken? eGFR: ____________________ Date: ____________________
6. Has the member tried any of the following medications? (Check all that apply.)
   - ☐ Farxiga®
   - ☐ Xigduo XR®
   - ☐ Jardiance®
   - ☐ Synjardy IR/XR®
   - ☐ Trijardy XR®
   - ☐ Glyxambi®
7. Is there any other clinical information for this request?

   ____

Renewals Requests:

1. Does the member continue to meet all criteria that was met for initial approval?
   ☐ Yes ☐ No
2. Has the member had positive clinical response to the medication?
   ☐ Yes ☐ No
3. Does the member have any renal insufficiencies or renal disease?
   ☐ Yes ☐ No
4. Has the member experienced any unacceptable toxicity from the drug?
   ☐ Yes ☐ No If **Yes**, please explain:

   ____

____ ____________________

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

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Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
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