MHLA Empagliflozin (Jardiance®) or Canagliflozin (Invokana®) Prior Authorization Form

Instructions

1. Please fill out all sections of the form on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes, lab data, to support the PA request. Incomplete forms will be filed as incomplete.
2. Submit complete form along with complete documents via Email: priorauth@dhs.lacounty.gov or Fax: 310-669-5609
3. Dispensing Pharmacy: Acknowledge that completed forms fulfill approval criteria and have been submitted via email/fax; claims will process following acknowledgment as prompted when billing online [clarification code 7]. Claims with PA forms are subject to audit.

Notes

1. Authorizations are limited to a maximum of **twelve (12) months** of therapy.
   Additional authorization is required for any use after this initial 12-month period.
2. Please complete **ALL** areas below, as incomplete prior authorization requests **MAY AFFECT THE OUTCOME** of this request.

Patient Information: This must be filled out COMPLETELY to ensure HIPAA compliance					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		CA	Zip Code:	
Date of Birth:	☐ Male ☐ Female	Height:	Weight:	Allergies:	
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:			
Insurance/Coverage Information					
Primary Insurance/Coverage Name: **My Health LA**		MHLA Patient ID Number:			
Prescriber Information					
First Name:	Last Name:		Specialty:		
Address:	City:		CA	Zip Code:	
Requestor (if different than prescriber):		Office Contact Person:			
NPI Number (individual):		Phone Number:			
DEA Number (if required):		Fax Number (in HIPAA compliant area):			
Email Address:					
Jardiance® or Invokana® Prescription Information					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:		
☐ New Therapy ☐ Renewal If Renewal: Date Therapy Initiated:		Duration of Therapy (specific dates):			
How did the patient receive the medication? ☐ Patient Assistance Program. If PAP denied, please attach denial letter. ☐ Other (explain): _____					

Medication History for This Condition		
Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

LA County DHS P&T Committee Approved: 8/2021

MHLA Empagliflozin (Jardiance®) or Canagliflozin (Invokana®) Prior Authorization Form Continued

Patient Name:	MHLA Patient ID#:

STEP 1: EXCLUSION CRITERIA *(If any of the following criteria apply, the patient does **NOT** qualify for empagliflozin/canagliflozin use)*

Patient diagnosed with Type 1 Diabetes or for treatment of diabetic ketoacidosis	Patient currently admitted for inpatient care
Patient has known hypersensitivity to empagliflozin/canagliflozin or any excipients in empagliflozin/canagliflozin	Patient has recurrent mycotic genital infections
Patient has eGFR of less than 30mL/min/1.73m^2	*Caution: use in uncircumcised males, provider should discuss cleaning/hygiene routines
Patient is in the second or third trimester of pregnancy or breastfeeding	Patient is under 18 years of age

☐ Patient has no exclusion criteria listed above

STEP 2a: APPROVAL CRITERIA AS 2nd-LINE THERAPY FOR CARDIOVASCULAR RISK REDUCTION IN A PATIENT WITH T2DM and CAD *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval)*
Note: Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐	Diagnosis of Type 2 Diabetes with a history of coronary artery disease (CAD)
☐	Patient on Metformin or has contraindication/intolerance to Metformin and requires add-on of Empagliflozin/Canagliflozin for cardiovascular protection *for coronary artery disease (CAD) patients, empagliflozin (Jardiance®)/canagliflozin (Invokana®) may be used concurrently with insulin
☐	Patient has an eGFR of greater than/equal to 30mL/min/1.73m^2; patient's current eGFR: _____ mL/min/1.73m^2

STEP 2b: APPROVAL CRITERIA AS 2nd-LINE THERAPY FOR PROTEINURIA *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval).* **Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐	Diagnosis of Type 2 Diabetes with Urine MicAlbumin-to-Creatinine Ratio of > 300mg/g
☐	Patient has an eGFR of greater than or equal to 30mL/min/1.73m2; patient's current eGFR: _____ mL/min/1.73m2
☐	Patient currently on or has contraindication to angiotensin converting enzyme inhibitor (ACE-i) or angiotensin receptor blocker (ARB)

STEP 2c: APPROVAL CRITERIA AS 3rd or 4th-LINE THERAPY FOR T2DM *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval)*. **Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐ New Therapy **OR** ☐ Continuation of therapy; HbA1c **MUST BE** less than 8%

☐	Diagnosis of Type 2 Diabetes and has a HbA1c between 0.5% and 2% above HbA1c target (see HbA1c target expected practice) Target HbA1c _____, Current HbA1c _____
☐	Patient is not currently on insulin therapy
☐	Patient has an eGFR of greater than or equal to 30mL/min/1.73m2; patient's current eGFR: _____ mL/min/1.73m2
☐	Patient has failed/contraindication or is intolerant to maximal doses of metformin + sulfonylurea + thiazolidinedione (using empagliflozin/canagliflozin as 4th line agent)

STEP 3: DOSAGE *(Check the appropriate dosage)*

☐	Empagliflozin (Jardiance®) 25 mg; half tablet daily [effective dose of 12.5mg] *(if on a sulfonylurea, sulfonylurea dose should also be halved when initiating empagliflozin to prevent hypoglycemia and can be increased back to full dose if no hypoglycemia in 1 month)*	☐	Other _____ (Specify dose and frequency: explain in Step 4)
☐	Canagliflozin (Invokana®) 100mg: one tablet daily *(if on a sulfonylurea, sulfonylurea dose should also be halved when initiating canagliflozin to prevent hypoglycemia and can be increased back to full dose if no hypoglycemia in 1 month)*	☐	Other _____ (Specify dose and frequency: explain in Step 4)

STEP 4: ADDITIONAL EXPLANATION *(For additional comments, please attach to form)*

STEP 5: ATTACH RELEVANT PROGRESS NOTE, LABS, and CURRENT MEDS *(Required)*

STEP 6: PRESCRIBER SIGNATURE

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**: _____

Plan Use Only:

Pharmacy Review: Approval criteria met? ☐ **YES** ☐ **NO** See instructions at top of form for next step following review.	Patient's A1c %:	Date of A1c:
Date Received:	Date of Decision:	Pharmacist Reviewer:
Medical Review: ☐ **Approved**		☐ **Denied**
Date Received:	Date of Decision:	
CMO or Designee:		

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