CAREFIRST - VA EXCHANGE 5T
Antidiabetic Agents Step Therapy (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Antidiabetic Agents Step Therapy (HMF).

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1.	Has the patient been receiving the requested drug for at least 3 months?	**Y** ☐	**N** ☐
2.	Has the patient demonstrated a reduction in A1c (hemoglobin A1c) since starting this therapy?	**Y** ☐	**N** ☐
3.	Is this request for Farxiga (dapagliflozin), Invokana (canagliflozin), Jardiance (empagliflozin), Ozempic (semaglutide), or Victoza (liraglutide)?	**Y** ☐	**N** ☐
4.	Is this request for SymlinPen (pramlintide acetate)?	**Y** ☐	**N** ☐
5.	Does the patient have a diagnosis of type 2 diabetes mellitus?	**Y** ☐	**N** ☐
6.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to metformin?	**Y** ☐	**N** ☐
7.	Does the patient require combination therapy AND have an A1c (hemoglobin A1c) of 7.5 percent or greater?	**Y** ☐	**N** ☐
8.	Is this request for Farxiga (dapagliflozin), Invokana (canagliflozin), Jardiance (empagliflozin), Ozempic (semaglutide), or Victoza (liraglutide)?	**Y** ☐	**N** ☐
9.	Does the patient have established cardiovascular disease?	**Y** ☐	**N** ☐
10.	Is this request for Invokana (canagliflozin)?	**Y** ☐	**N** ☐

11.	Does the patient have diabetic nephropathy with albuminuria greater than 300 mg per day?	**Y** ☐	**N** ☐
12.	Is this request for Farxiga (dapagliflozin)?	**Y** ☐	**N** ☐
13.	Does the patient have multiple cardiovascular risk factors?	**Y** ☐	**N** ☐
14.	Does the patient have a diagnosis of diabetes mellitus?	**Y** ☐	**N** ☐
15.	Has the patient failed to achieve desired glucose control despite receiving optimal insulin therapy, including mealtime insulin?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date