AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Select one below)

❑ **alogliptin** (Nesina® ABA)	❑ **Nesina®** (alogliptin)
❑ **alogliptin-pioglitazone** (Oseni® ABA)	❑ **Oseni®** (alogliptin-pioglitazone)
❑ **alogliptin-metformin** (Kazano® ABA)	❑ **Kazano®** (alogliptin-metformin)
❑ **saxagliptin-metformin ER** (Kombiglyze™ XR)	❑ **saxagliptin** (Onglyza™)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **For Nesina®, saxagliptin (Onglyza), alogliptin-pioglitazone (Oseni®), or alogliptin**

- ❑ Patient has tried and failed **90 days** of therapy with Januvia®

AND

(Continued on next page)

- ❑ Patient has tried and failed **90 days** of therapy with Tradjenta®

- ❑ **For Kazano®, saxagliptin-metformin ER (Kombiglyze™ XR), or alogliptin-metformin**

- ❑ Patient has tried and failed **90 days** of therapy with Janumet® **or** Janumet® XR

AND

- ❑ Patient has tried and failed **90 days** of therapy with Jentadueto®

***** Not all drugs may be covered under every Plan***

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by the Pharmacy and Therapeutics Committee:** 10/15/2009
REVISED/UPDATED: ~~6/10/2011; 8/22/2011; 5/17/2012; 10/9/2012; 3/21/2013; 6/18/13; 4/10/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/22/2016; 8/15/2017; 6/18/2018; (Reformatted) 6/19/2019;06/04/2020;~~ **10/27/2023**;