NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
SGLT2 Inhibitors and Combinations

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Requests for SGLT 2 Inhibitors and Combinations for both preferred and non preferred products 1-6):

1. Does the beneficiary have a diagnosis of heart failure? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of Type 2 Diabetes? ☐ **Yes** ☐ **No**
3. Has the beneficiary had a trial and failure or insufficient response to metformin therapy or other metformin containing products? ☐ **Yes** ☐ **No**
4. Has the beneficiary had a contraindication or adverse event to metformin? ☐ **Yes** ☐ **No**
5. Has the beneficiary established ASCVD, heart failure, or Chronic Kidney Disease? ☐ **Yes** ☐ **No**
6. Is the beneficiary considered high-risk for ASCVD as defined as ≥ 55 years of age with ≥ 2 additional risk factors (e.g. smoking, obesity, hypertension, dyslipidemia, or albuminuria)? ☐ **Yes** ☐ **No**
7. **For non-preferred products (in addition to questions 1-6),** has the beneficiary tried and failed or experienced an insufficient response to at least two preferred products or have a clinical reason that preferred products cannot be tried? ☐ **Yes** ☐ **No**
List:_____

Continuation Requests for SGLT 2 Inhibitors and Combinations for both preferred and non preferred products:

1. Has the beneficiary improved while on this medication? ☐ **Yes** ☐ **No (Medical Documentation should be attached to this request)**
2. Are individual clinical goals that were set by the provider being met? ☐ **Yes** ☐ **No**
3. Is the beneficiary continuing to make adequate progress towards treatment goals? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505