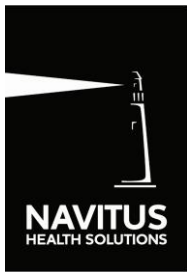




**TEXAS MEDICAID**  
**Clinical Edit Prior Authorization**  
**Sodium-Glucose Cotransporter-2 (SGLT2)**  
**Inhibitor Combination Agents:**  
**INVOKAMET (XR), SEGLUROMET, SYNJARDY (XR),**  
**XIGDUO XR**

<b>STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING</b>	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
<b>STEP 2: MEDICATION INFORMATION</b>	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:
Patient's Primary Diagnosis: _____ ICD 10 Code: _____	
Indicate the drug's formulary status: *(Formulary available at <a href="http://www.txvendordrug.com">www.txvendordrug.com</a> ) <input type="checkbox"/> Non-Preferred Drug ( <b>NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies</b> ) <b>OR</b> <input type="checkbox"/> Preferred Drug ( <b>Go to Step 4</b> ) <b>OR</b> <input type="checkbox"/> No Status, Drug is not in a Market Basket ( <b>Go to Step 4</b> ) <b>OR</b> <input type="checkbox"/> N/A as this request is for a CHIP / PERINATE client ( <b>Go to Step 4</b> )	
<b>STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT</b>	
1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the last 180 days? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #2)	
2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #3)	



3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes (Go to Step 4 Question 1)  No (Deny)

**STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA**

1. Is the client greater than or equal to ( $\geq$ ) 18 years of age?

Yes (Go to #2)  No (Deny)

2. Does the client have a diagnosis of type 2 diabetes in the last 730 days?

Yes (Go to #3)  No (Deny)

3. Does the client have a diagnosis of hepatic impairment in the last 365 days?

Yes (Deny)  No (Go to #4)

4. Does the client have a diagnosis of severe renal impairment (eGFR less than 30 mL/minute/1.73m<sup>2</sup>), end stage renal disease (ESRD), or dialysis in the last 365 days?

Yes (Deny)  No (Go to #5)

5. Is the daily dose less than or equal to ( $\leq$ ) 2 tablets daily?

Yes (Approve – 365 days)  No (Deny)

**STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
For questions, please call Navitus Customer Care at 1-877-908-6023.