TEXAS MEDICAID
Clinical Edit Prior Authorization
Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitor Single Agents:
FARXIGA, INVOKANA, JARDIANCE, STEGLATRO

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
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:
STEP 2: MEDICATION INFORMATION	
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 www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4, Question 1) ☐ 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 (≥) 18 years of age?

☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a history of dialysis in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #3)

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

☐ Yes (And the request is for INVOKANA or JARDIANCE, go to #7)
☐ Yes (And the request is for STEGLATRO, go to #6)
☐ Yes (And the request is for FARXIGA, go to #5)
☐ No (And the request is for FARXIGA, go to #4)
☐ No (And the request is for INVOKANA, JARDIANCE, or STEGLATRO, deny)

4. Does the client have a diagnosis of heart failure with reduce ejection fraction (New York Heart Association (NYHA) class II-IV) or chronic kidney disease in the last 730 days?

☐ Yes (Go to #7) ☐ No (Deny)

5. Does the client have a diagnosis of severe renal impairment (estimated glomerular filtration rate (eGFR) less than 45 mL/minute/1.73m^2) in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #7)

6. Does the client have a diagnosis of severe renal impairment (estimated glomerular filtration rate (eGFR) less than 30 mL/minute/1.73m^2) or end stage renal disease (ESRD) in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #7)

7. Is the daily dose less than or equal to (≤) 1 tablet 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.