



Prior Authorization Request Form – Januvia®, Janumet®, Onglyza®, Kombiglyze® XR, Tradjenta®

Instructions:

This form is to be used by participating providers to request coverage for Januvia, Janumet, Onglyza, Kombiglyze XR, or Tradjenta. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
Fax: 1-800-918-7542

A DPP-4 inhibitor step therapy program has been developed to encourage the use of 1st-line therapies before 2nd-line therapies are used for the same indication. When approved, quantity limits apply.

First-line therapies:

Metformin or a metformin-containing product

Second-line therapies:

Januvia (sitagliptin)
Janumet (sitagliptin-metformin)
Onglyza (saxagliptin)
Kombiglyze XR (saxagliptin-metformin)
Tradjenta (linagliptin)

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name & Specialty:	5. Contact Person at Office:
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6. Prescriber's FAX & Telephone Number: Fax: () Tel: ()
Mailing Address:

7. Requested Drug: <input type="checkbox"/> Januvia <input type="checkbox"/> Janumet <input type="checkbox"/> Onglyza <input type="checkbox"/> Kombiglyze XR <input type="checkbox"/> Tradjenta	8. Dose, Frequency, and Duration of the Requested Drug:
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9. Does the member have a diagnosis of Type 2 Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
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10. Has the member been started and stabilized on the requested drug? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, please provide the duration of the therapy = _____
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11. Has the member previously tried the following medications?	
Drug Name (please check all that apply)	Response (please check all that apply)
<input type="checkbox"/> metformin or metformin-containing product Please specify: _____	<input type="checkbox"/> non-response <input type="checkbox"/> side-effect <input type="checkbox"/> allergy <input type="checkbox"/> contraindication Please specify: _____
<input type="checkbox"/> Januvia	<input type="checkbox"/> non-response <input type="checkbox"/> side-effect <input type="checkbox"/> allergy <input type="checkbox"/> contraindication Please specify: _____
<input type="checkbox"/> Onglyza	<input type="checkbox"/> non-response <input type="checkbox"/> side-effect <input type="checkbox"/> allergy <input type="checkbox"/> contraindication Please specify: _____
<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> non-response <input type="checkbox"/> side-effect <input type="checkbox"/> allergy <input type="checkbox"/> contraindication Please specify: _____

12. Prescriber Comments:

Signature:

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.

Prescriber's signature

Date