GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

HYPOGLYCEMICS, SGLT2 INHIBITORS PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for Hypoglycemics, SGLT2 Inhibitors and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Phone number of office contact:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis (*Submit documentation*):	Dx code (*required*):	
Does the beneficiary have a diagnosis of type 2 diabetes?	☐ Yes – *Submit documentation of diagnosis* ☐ No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*	
Requests for a NON-PREFERRED medication: Please list the preferred Hypoglycemics, SGLT2 Inhibitors that the beneficiary has had a therapeutic failure, contraindication, or intolerance to. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class*	*Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*	

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Has a history of trial and failure of maximum tolerated doses of metformin as evidenced by HbA1c results. Provide HbA1c value: ________
☐ Has a contraindication or intolerance to metformin
☐ Requires initial dual therapy with metformin based on HbA1c as defined by current ADA and/or AACE/ACE guidelines Provide HbA1c value: ________
☐ Has the following comorbidities:
- ☐ cardiovascular disease or at least 2 risk factors for cardiovascular disease
- ☐ at least 2 risk factors for cardiovascular disease. Please provide the member's risk factors for CVD: ______________________
- ☐ heart failure
- ☐ chronic kidney disease

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: