



Please complete ALL information below and fax your request to 1-888-671-5285

### DPP-4 Inhibitors Coverage Determination Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		Office Contact:
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name: Select one of the following:			Strength:		Dosage Form:
<input type="checkbox"/> Request is for <b>GENERIC</b>					
<input type="checkbox"/> Request is for <b>BRAND</b> (unable to take the generic)					
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			Directions for Use:		
Clinical Information <small>(required)</small>					
<b>Select the Type(s) of Coverage Determination Requested:</b>					
<input type="checkbox"/> <b>Non-Formulary</b> - Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.					
<input type="checkbox"/> <b>Step Therapy</b> - Request is for an exception to try another drug before the requested drug being prescribed.					
<input type="checkbox"/> <b>Quantity Limit</b> - Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Type 2 diabetes mellitus					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Select the medication(s) the patient has a history of trial and failure, or intolerance to:</b>					
<input type="checkbox"/> Alogliptin		<input type="checkbox"/> Metformin used in combination with Januvia			
<input type="checkbox"/> Alogliptin used in combination with pioglitazone		<input type="checkbox"/> Metformin used in combination with Onglyza			
<input type="checkbox"/> Alogliptin/metformin		<input type="checkbox"/> Metformin ER (generic Glucophage XR) used in combination with alogliptin			
<input type="checkbox"/> Alogliptin/pioglitazone		<input type="checkbox"/> Metformin ER (generic Glucophage XR) used in combination with Januvia			
<input type="checkbox"/> Janumet		<input type="checkbox"/> Metformin ER (generic Glucophage XR) used in combination with Onglyza			
<input type="checkbox"/> Janumet XR		<input type="checkbox"/> Onglyza			
<input type="checkbox"/> Januvia		<input type="checkbox"/> Onglyza used in combination with pioglitazone			
<input type="checkbox"/> Januvia used in combination with pioglitazone		<input type="checkbox"/> Riomet used in combination with alogliptin			
<input type="checkbox"/> Juvisync		<input type="checkbox"/> Riomet used in combination with Januvia			
<input type="checkbox"/> Kombiglyze XR		<input type="checkbox"/> Riomet used in combination with Onglyza			
<input type="checkbox"/> Metformin used in combination with alogliptin					
<input type="checkbox"/> Other drugs in the same class. Please specify: _____					
<input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____					
<b>Quantity limit requests:</b>					
Is there a high risk of significant adverse clinical outcome with medication change or dosage change? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If <b>yes</b> , please specify: _____					

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## DPP-4 Inhibitors Coverage Determination Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.