



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

Qtern® Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
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 (required)					
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)			Strength:	Dosage Form:	
<input type="checkbox"/> Check if request is for continuation of therapy			Directions for Use:		
Clinical Information (required)					
Select the Type(s) of Coverage Determination Requested:					
<input type="checkbox"/> Non-Formulary - 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"/> Step Therapy - Request is for an exception to try another drug before the requested drug being prescribed.					
<input type="checkbox"/> Quantity Limit - Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____					
Select the diagnosis below:					
<input type="checkbox"/> Type 2 diabetes mellitus					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Select the medication(s) the patient has a history of trial and failure, or intolerance to:					
<input type="checkbox"/> Actoplus Met	<input type="checkbox"/> Januvia used in combination with Invokana				
<input type="checkbox"/> Actoplus Met XR	<input type="checkbox"/> Januvia used in combination with Jardiance				
<input type="checkbox"/> Alogliptin used in combination with Invokana	<input type="checkbox"/> Jardiance				
<input type="checkbox"/> Alogliptin used in combination with Jardiance	<input type="checkbox"/> Kombiglyze XR				
<input type="checkbox"/> Alogliptin-metformin	<input type="checkbox"/> Metformin				
<input type="checkbox"/> Glipizide-metformin	<input type="checkbox"/> Metformin extended-release (ER) [generic Glucophage XR]				
<input type="checkbox"/> Glucophage	<input type="checkbox"/> Onglyza used in combination with Invokana				
<input type="checkbox"/> Glucophage XR	<input type="checkbox"/> Onglyza used in combination with Jardiance				
<input type="checkbox"/> Glyxambi	<input type="checkbox"/> Pioglitazone-metformin				
<input type="checkbox"/> Invokamet	<input type="checkbox"/> Repaglinide-metformin				
<input type="checkbox"/> Invokamet XR	<input type="checkbox"/> Riomet				
<input type="checkbox"/> Invokana	<input type="checkbox"/> Synjardy				
<input type="checkbox"/> Janumet	<input type="checkbox"/> Synjardy XR				
<input type="checkbox"/> Janumet XR					
<input type="checkbox"/> Other drugs in the same class. Please specify: _____					
<input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____					
Quantity limit requests:					
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 yes , please specify: _____					

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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?

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