



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

Steglatro[®] Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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) <input type="checkbox"/> Check if request is for continuation of therapy	Strength:	Dosage Form:
Directions for Use:		

Clinical Information (required)																				
<p>Select the Type(s) of Coverage Determination Requested:</p> <p><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.</p> <p><input type="checkbox"/> Step Therapy- Request is for an exception to try another drug before the requested drug being prescribed.</p>																				
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Type 2 diabetes mellitus</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>																				
<p>Select the medication(s) the patient has a history of trial and failure, or intolerance to:</p> <table border="0"> <tr> <td><input type="checkbox"/> Actoplus Met</td> <td><input type="checkbox"/> Janumet XR</td> </tr> <tr> <td><input type="checkbox"/> Actoplus Met XR</td> <td><input type="checkbox"/> Jardiance</td> </tr> <tr> <td><input type="checkbox"/> Alogliptin-metformin</td> <td><input type="checkbox"/> Kombiglyze XR</td> </tr> <tr> <td><input type="checkbox"/> Glipizide-metformin</td> <td><input type="checkbox"/> Metformin</td> </tr> <tr> <td><input type="checkbox"/> Glucophage</td> <td><input type="checkbox"/> Metformin extended-release (ER) [generic Glucophage XR]</td> </tr> <tr> <td><input type="checkbox"/> Glucophage XR</td> <td><input type="checkbox"/> Pioglitazone-metformin</td> </tr> <tr> <td><input type="checkbox"/> Invokamet</td> <td><input type="checkbox"/> Repaglinide-metformin</td> </tr> <tr> <td><input type="checkbox"/> Invokamet XR</td> <td><input type="checkbox"/> Riomet</td> </tr> <tr> <td><input type="checkbox"/> Invokana</td> <td><input type="checkbox"/> Synjardy</td> </tr> <tr> <td><input type="checkbox"/> Janumet</td> <td><input type="checkbox"/> Synjardy XR</td> </tr> </table> <p><input type="checkbox"/> Other drugs in the same class. Please specify: _____</p> <p><input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____</p>	<input type="checkbox"/> Actoplus Met	<input type="checkbox"/> Janumet XR	<input type="checkbox"/> Actoplus Met XR	<input type="checkbox"/> Jardiance	<input type="checkbox"/> Alogliptin-metformin	<input type="checkbox"/> Kombiglyze XR	<input type="checkbox"/> Glipizide-metformin	<input type="checkbox"/> Metformin	<input type="checkbox"/> Glucophage	<input type="checkbox"/> Metformin extended-release (ER) [generic Glucophage XR]	<input type="checkbox"/> Glucophage XR	<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
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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.

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