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

Steglujan® 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: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **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.

❑ **Step Therapy**- Request is for an exception to try another drug before the requested drug being prescribed.

Select the diagnosis below:

❑ Type 2 diabetes mellitus

❑ Other diagnosis: ____ ICD-10 Code(s): _______________________________________

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

❑ Actoplus Met
❑ Actoplus Met XR
❑ Alogliptin used in combination with Invokana
❑ Alogliptin used in combination with Jardiance
❑ Alogliptin-metformin
❑ Glipizide-metformin
❑ Glucophage
❑ Glucophage XR
❑ Glyxambi
❑ Invokamet
❑ Invokamet XR
❑ Invokana
❑ Janumet
❑ Janumet XR
❑ Januvia used in combination with Invokana
❑ Januvia used in combination with Jardiance
❑ Jardiance
❑ Kombiglyze XR
❑ Metformin
❑ Metformin extended-release (ER) [generic Glucophage XR]
❑ Onglyza used in combination with Invokana
❑ Onglyza used in combination with Jardiance
❑ Pioglitazone-metformin
❑ Repaglinide-metformin
❑ Riomet
❑ Synjardy
❑ Synjardy XR
❑ Other drugs in the same class. Please specify: ____
❑ Other therapeutic equivalent alternatives. Please specify: ____

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Steglujan_FSPartD_2019Feb-W