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

Kombiglyze® XR & Onglyza® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Type 2 diabetes mellitus

❑ Other diagnosis: ____________________________ ICD-10 Code(s): ____________________________

Continuation of therapy:

Is this for a continuation of prior therapy? ❑ **Yes** ❑ **No**

Select the medication(s) the patient has a history of:

❑ Glipizide-metformin
❑ Glyburide-metformin
❑ Janumet
❑ Janumet XR
❑ Januvia
❑ Jentadueto
❑ Jentadueto XR
❑ Metformin
❑ Metformin ER
❑ Pioglitazone-metformin
❑ Tradjenta

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.

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.**

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