



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

Steglujan® Prior Authorization Request Form

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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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Type 2 diabetes mellitus	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Select the medications the patient has had an inadequate response to or inability to tolerate:	
<input type="checkbox"/> Invokana	
<input type="checkbox"/> Invokamet	
<input type="checkbox"/> Jardiance	
<input type="checkbox"/> Synjardy	

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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