

## SGLT2 Inhibitors and Combinations

### Member Information

1. Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Trillium ID #: \_\_\_\_\_ 4. Date of Birth: \_\_\_\_\_ 5. Gender: \_\_\_\_\_

### Prescriber Information

1. Prescriber Name: \_\_\_\_\_ 2. NPI #: \_\_\_\_\_  
3. Requestor Name (Nurse/Office Staff): \_\_\_\_\_  
4. Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
5. Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax #: \_\_\_\_\_

### Drug Information

1. Drug Name: \_\_\_\_\_ 2. Strength: \_\_\_\_\_ 3. Quantity per 30 Days: \_\_\_\_\_  
4. Length of Therapy:  30 Days  60 Days  90 Days  120 Days  180 Days  365 Days  Other \_\_\_\_\_

### Clinical Information

#### Initial Requests for SGLT 2 Inhibitors and Combinations for both preferred and non preferred products 1-6):

1. Does the member have a diagnosis of heart failure?  Yes  No
2. Does the member have a diagnosis of Type 2 Diabetes?  Yes  No
3. Has the member had a trial and failure or insufficient response to metformin therapy or other metformin containing products?  Yes  No
4. Has the member had a contraindication or adverse event to metformin?  Yes  No
5. Has the member established ASCVD, heart failure, or Chronic Kidney Disease?  Yes  No
6. Is the member considered high-risk for ASCVD as defined as  $\geq 55$  years of age with  $\geq 2$  additional risk factors (e.g. smoking, obesity, hypertension, dyslipidemia, or albuminuria)?  Yes  No
7. **For non-preferred products (in addition to questions 1-6),** has the member tried and failed or experienced an insufficient response to at least two preferred products or have a clinical reason that preferred products cannot be tried?  Yes  No  
List: \_\_\_\_\_

#### Continuation Requests for SGLT 2 Inhibitors and Combinations for both preferred and non-preferred products:

1. Has the member improved while on this medication?  Yes  No **(Medical Documentation should be attached to this request)**
2. Are individual clinical goals that were set by the provider being met?  Yes  No
3. Is the member continuing to make adequate progress towards treatment goals?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.