Updated: 08/2020
DMMA Approved: 09/2020

Request for Prior Authorization for Farxiga for Heart Failure
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Farxiga for Heart Failure require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Farxiga for Heart Failure Prior Authorization Criteria:

Coverage may be provided with a diagnosis of heart failure (HF) and the following criteria is met:

- Diagnosis of HF with NYHA class II-IV
- Member must be 18 years of age or older
- Must be prescribed by or in consultation with a cardiologist
- Member must have a reduced left ventricular ejection fraction of 40% or less
- Member has tried and failed (which will be verified via pharmacy claims if available), had an intolerance, contraindication or is currently taking **one** of the following:
    - Beta blocker
    - ACEi/ARB/ARNI
    - Diuretic
    - Aldosterone antagonist (if an aldosterone antagonist is indicated)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria:**
    - Must provide documentation demonstrating the member is tolerating therapy and has had an improvement in their condition.
    - Member has had a reduction in the number of hospitalizations for heart failure or urgent heart failure visits
    - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
        - Documentation the member has at least 1 fill of the requested medication in the past 45 days

- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or

peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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FARXIGA TO TREAT HEART FAILURE
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: **ICD-10:** _____

Does the member have heart failure with a NYHA class II-IV and a reduced ejection fraction ≤ 40%? ☐ Yes ☐ No

Has the member tried and failed or had an intolerance or contraindication to **one** of the following (please list which agents below)? ☐ Yes ☐ No

- Beta blocker
- ACEi/ARB/ARNI
- Diuretic
- Aldosterone antagonist (if an aldosterone antagonist is indicated)

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date