

# Prior Authorization Request Form for Victoza (liraglutide)



5633

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> <li>The provider may call: <b>1-866-684-4488</b> or the completed form may be faxed to: <b>1-866-684-4477</b></li> <li>The patient may attach the completed form to the prescription and mail it to: <b>Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b> or email the form only to: <b>TPharmPA@express-scripts.com</b></li> </ul>
-----------------------------	--

Prior authorization criteria and a copy of this form are available at: [http://pec.ha.osd.mil/forms\\_criteria.php](http://pec.ha.osd.mil/forms_criteria.php). This prior authorization has no expiration date.

**Step 1** Please complete patient and physician information (please print):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

2	1. Does the patient have a diagnosis of type 2 diabetes mellitus?	Yes Proceed to Question 2	No Coverage not approved
	2. Has the patient tried at least ONE of the following and failed to achieve glycemic control: <b>METFORMIN</b> (alone or in combination) or a <b>SULFONYLUREA</b> (alone or in combination)?	Yes <b>Jump</b> to question 6	No Proceed to question 3
	3. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	Yes <b>Jump</b> to question 6	No Proceed to question 4
	4. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	Yes <b>Jump</b> to question 6	No Proceed to question 5
	5. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?	Yes Proceed to Question 6	No Coverage not approved
	6. Does the patient have a contraindication to Byetta (exenatide)?	Yes Sign and date below	No Proceed to question 7
	7. Has the patient used Byetta and had an inadequate response?	Yes Sign and date below	No Proceed to question 8
	8. Has the patient used Byetta and experienced an adverse event with Byetta that is not expected to occur with Victoza?	Yes Sign and date below	No Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge.

Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date