Prior Authorization Form

Victoza

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Victoza.

Drug Name (select from list of drugs shown)
Victoza (liraglutide)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient been receiving GLP-1 Agonist therapy for at least 3 months? Y N

[Note: Examples of GLP-1 Agonists are Adlyxin, Bydureon, Byetta, Ozempic,Tanzeum, Trulicity, Victoza]

[If no, then skip to question 3.]

2. Has the patient demonstrated a reduction in A1c (hemoglobin A1c) since starting GLP-1 Agonist therapy? Y N

[If no, then skip to question 6.]

[If yes, then skip to question 7.]

3.	Does the patient have a diagnosis of type 2 diabetes mellitus?	Y N
4.	Has the patient experienced an inadequate treatment response, intolerance or contraindication to metformin?	Y N
	[If yes, then skip to question 7.]	
5.	Does the patient require combination therapy AND have an A1c (hemoglobin A1c) of 7.5 percent or greater?	Y N
6.	Does the patient have established cardiovascular disease?	Y N
7.	Does the patient require more than 3 prefilled pens per month (or 9 prefilled pens per 3 months)?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date