## TRICARE Prior Authorization Request Form for Adlyxin, Byetta, Bydureon BCise, Victoza



7231 Parkway Drive, Suite 100, Hanover, MD 21076

## **FAX Completed Form and Applicable Progress Notes to:** (410) 424-4037

## **USFHP Pharmacy Prior Authorization Form**

To be completed by Requesting provider				
Drug Name:	Strength:			
Dosage/Frequency (SIG):	Duration of Therapy:			

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Step	Please complete patient and physician information					
1	Patient Name:  Address:	Physician Name: Address:				
	Sponsor ID #	Phone #:				
	Date of Birth:	Secure Fax #:				
Step	Please complete the clinical assessment:					
2	1. Trulicity is available on the UF and has an indication to reduce the risk of major adverse cardiovascular events in adults with Type 2 diabetes mellitus (T2DM) who have established cardiovascular disease or multiple cardiovascurisk factors: Adlyxin, Byetta and Bydureon BCis do not have this indication. Providers are encouraged to write a new prescription for Trulicity.	lar	☐ Acknowledged Proceed to question 2			
	2. Does the patient have a diagnosis of type 2 diabetes mellitus?	□ Ye Proceed to d		□ No STOP  Coverage not approved		
	3. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	☐ Yeroceed to q		☐ No Proceed to question 4		
	4. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatmen with metformin or a history of lactic acidosis?	□ Y		☐ No Proceed to question 5		
	5. Does the patient have a contraindication to metformin?	□ YeProceed to q		□ No STOP Coverage not approved		

## TRICARE Prior Authorization Request Form for Adlyxin, Byetta, Bydureon BCise, Victoza

			□ No				
	6. Has the patient had an inadequate response with Trulicity and Ozempic?	☐ Yes Sign and date below	STOP Coverage not approved				
Step 3	I certify the above is true to the best of my knowledge. Please sign and date:						
	Prescriber Signature	 Date	107.0 t t 00001				
			[27 September 2023]				
	rnal Use Only						
Appro		Duration of Approval:month(s)					
☐ Denie		Authorized By:					
☐ Incom	pplete/Other:	PA#:					
Date Fax	red to MD:	Date Decision Rendered:					