



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

6. Has the patient had an inadequate response with Trulicity and Ozempic?

Yes  
Sign and date below

No  
**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

[27 September 2023]

### For Internal Use Only

<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: