TRICARE Prior Authorization Request Form for

Soliqua (lixisenatide/insulin glargine)

JOHNS HOPKINS
HEALTH PLANS
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

Clinical Documentation must accompany form in order for a determination to be made.

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

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

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

1. Provider acknowledges Ozempic, and Trulicity are the Department of Defense's preferred Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs), and Lantus is the preferred basal insulin.	Proceed to question 2	
2. Will the requested medication be used as an adjunct to diet and exercise to improve glycemic control in adults with Type 2 diabetes mellitus inadequately controlled on a basal insulin (less than 60 units daily)?	☐ Yes Proceed to question 3	☐ No **Coverage not approved**
3. Has the patient had an inadequate response to Ozempic and Trulicity?	☐ 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

[18 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: