TRICARE Prior Authorization Request Form for
liraglutide (Victoza), exenatide

JOHNS HOPKINS
HEALTH PLANS

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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.

Prior authorization does not expire.

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. What is the diagnosis or indication?	☐ Type 2 diabetes mellitus – Proceed to question **2** ☐ Weight loss in patients who do not have diabetes - **STOP - Coverage not approved** ☐ Other diagnosis – **STOP - Coverage not approved**	
2. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. Has the patient experienced a history of lactic acidosis?	☐ Yes Proceed to question **5**	☐ No Proceed to question **4**
4. Does the patient have a contraindication to metformin (for example, impaired renal function)?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient had an adverse reaction, inadequate response, or contraindication to all of the following: Trulicity, Ozempic and Mounjaro?	☐ 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

[05 August 2026]

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