**Victoza® Prior Authorization Request Form**

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

<table>
<thead>
<tr>
<th>Member Information (required)</th>
<th>Provider Information (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name:</strong></td>
<td><strong>Provider Name:</strong></td>
</tr>
<tr>
<td><strong>Insurance ID#:</strong></td>
<td><strong>NP#:</strong></td>
</tr>
<tr>
<td><strong>Date of Birth:</strong></td>
<td><strong>Office Phone:</strong></td>
</tr>
<tr>
<td><strong>Street Address:</strong></td>
<td><strong>Office Fax:</strong></td>
</tr>
<tr>
<td><strong>City:</strong></td>
<td><strong>State:</strong></td>
</tr>
<tr>
<td><strong>Phone:</strong></td>
<td><strong>Zip:</strong></td>
</tr>
</tbody>
</table>

**Medication Information (required)**

<table>
<thead>
<tr>
<th>Medication Name:</th>
<th>Strength:</th>
<th>Dosage Form:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- Check if requesting brand
- Check if request is for continuation of therapy

**Clinical Information (required)**

- Select the diagnosis below:
  - Type 2 diabetes mellitus
  - Other diagnosis: ___________________________  ICD-10 Code(s): ___________________________

- Select the medications the patient has a failure, contraindication, or intolerance to:
  - Alogliptin-metformin
  - Bydureon BCise
  - Bydureon Pen
  - Byetta
  - Glyburide-metformin
  - Glyburide
  - Metformin
  - Metformin ER (generic Fortamet)
  - Metformin ER (generic Glucophage XR)
  - Metformin ER (generic Glumetza)
  - Pioglitazone-metformin
  - Repaglinide-metformin
  - Riomet
  - Trulicity

**Quantity limit requests:**

- What is the quantity requested per MONTH? ______

**What is the reason for exceeding the plan limitations?**

- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: ___________________________

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

______________________________________________________________________________________________________

______________________________________________________________________________________________________

Please note: This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.