# Victoza (liraglutide)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK:** HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTOR** (if different than prescriber)**:** | **OFFICE CONTACT PERSON:** |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES): | | | |

*Continued on next page.*

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ YES (if yes, complete below) ☐ NO | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE): | **DURATION OF THERAPY** (SPECIFY DATES): | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Type II diabetes<br>☐ Type II diabetes with established cardiovascular disease<br>☐ Other diagnosis: _____ICD-10_____ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Was the patient's most recent HbA1c in the past 6 months or prior to starting the requested medication thru samples or patient assistance 7.0% or greater? ☐ Yes ☐ No *Documentation of HbA1c level required.***

**Is the patient's estimated glomerular filtration rate (GFR) less than or equal to 45 mL/min/1.73 m2? ☐ Yes ☐ No *Documentation of GFR required.***

**Has the patient tried or is the patient currently taking metformin? ☐ Yes ☐ No**

**Has treatment with metformin been avoided due to lactic acidosis or elevated liver enzymes? ☐ Yes ☐ No**

**Does the patient have advanced liver disease with at least one of the following? ☐ Yes ☐ No**
**If yes, please select:**
**☐ Ascites**
**☐ Cirrhosis**
**☐ Hepatic encephalopathy**
**☐ Portal hypertension**

**Is the patient currently taking any of the following medications? ☐ Yes ☐ No**
**If yes, please select:**
**☐ Janumet/Janumet XR (sitagliptin/metformin)**
**☐ Januvia (sitagliptin)**
**☐ Jentadueto/Jentadueto XR (linagliptin/metformin)**
**☐ Kazano (alogliptin/metformin)**
**☐ Kombiglyze XR (saxagliptin/metformin)**
**☐ Nesina (alogliptin)**
**☐ Onglyza (saxagliptin)**
**☐ Oseni (alogliptin/pioglitazone)**
**☐ Tradjenta (linagliptin)**
**☐ Glyxambi (empagliflozin/linagliptin)**
**☐ Seglujan (ertugliflozin/sitagliptin)**
**☐ Qtern (dapagliflozin/saxagliptin)**

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**If the patient is taking any of the above medications, will concomitant therapy with those medications be discontinued? □ Yes □ No**

**Type II diabetes with established cardiovascular disease:**

**Is patient 50years of age or older with established cardiovascular disease(previous cardiovascular disease, cerebrovascular disease, or peripheral vascular disease)?**

**Please check at least one of the following with documentation in submitted chart notes:**

**□ History of MI or stroke or transient ischemic attack**
**□ History of unstable angina with ECG changes**
**□ History of coronary revascularization procedure**
**□ History of carotid revascularization procedure**
**□ History of peripheral revascularization procedure**
**□ History of symptomatic coronary heart disease documented by positive stress test, or cardiac imaging**
**□ Patient has more than 50% stenosis on angiography or imaging of coronary, carotid or lower extremities arteries**
**□ Patient has asymptomatic cardiac ischemia documented by positive nuclear imaging test or exercise test or stress echo or any cardiac imaging**
**□ Patient has chronic heart failure NYHA class II or III**
**□ Chronic renal impairment documented by eGFR below 60ml/min/1.73m$^2$ per modification of diet in renal disease(MDRD)**

**Is patient 60 years or older with at least 1 or more of the following risk factors?**

**Please check at least one with documentation in submitted chart notes:**

**□ microalbuminuria or proteinuria,**
**□ hypertension and left ventricular hypertrophy, left ventricular systolic or diastolic dysfunction, or**
**□ an ankle–brachial index [the ratio of the systolic blood pressure at the ankle to the systolic blood pressure in the arm] of less than 0.9,**

**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:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811