US Family Health Plan
Prior Authorization Request Form for
Adlyxin, Byetta, Ozempic, Victoza

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007** **usfamilyhealth.org/rx-pa**

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. Does the patient have a diagnosis of type 2 diabetes mellitus?	☐ Yes Proceed to question 2	☐ No 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 any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	☐ Yes Proceed to question 5	☐ No Proceed to question 4
4. Does the patient have a contraindication to metformin?	☐ Yes Proceed to question 5	☐ No **Coverage not approved**
5. Has the patient had an inadequate response with Bydureon/Bydureon BCise?	☐ Yes Proceed to question 7	☐ No Proceed to question 6
6. Is the patient unable to take Bydureon/Bydureon BCise due to impaired renal function?	☐ Yes Proceed to question 7	☐ No **Coverage not approved**
7. Has the patient had an inadequate response with 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 _____

[19 February 2020]