US Family Health Plan

Prior Authorization Request Form for

Soliqua (lixisenatide/insulin glargine)

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.

MAIL ORDER	**If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here** ☐ • The completed form may be **faxed** to **1-617-562-5296** OR • The patient may attach the completed form to the prescription and **mail** it to: **Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**	RETAIL	**If the prescription is to be filled at a retail pharmacy, check here** ☐ • The provider may **call 1-877-880-7007** OR • The completed form may be **faxed** to **617-562-5296**

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 Bydureon, Bydureon BCise, 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 Bydureon/ Bydureon BCise 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

[25 July 2018]