US Family Health Plan
Prior Authorization Request Form for
Adlyxin, Byetta, Bydureon BCise, 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**

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:

Question		
1. Trulicity is available on the UF and has an indication to reduce the risk of major adverse cardiovascular events in adults with Type 2 diabetes mellitus (T2DM) who have established cardiovascular disease or multiple cardiovascular risk factors: Adlyxin, Byetta and Bydureon BCise do not have this indication. Providers are encouraged to write a new prescription for Trulicity.	☐ Acknowledged Proceed to question **2**	
2. Does the patient have a diagnosis of type 2 diabetes mellitus?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. 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 **6**	☐ No Proceed to question **5**
5. Does the patient have a contraindication to metformin?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Has the patient had an inadequate response with Trulicity and Ozempic?	☐ Yes **Sign and date below**	☐ No Proceed to question **7**
7. Is the request for Victoza or Bydureon BCise?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved

8. Is the patient between 10 years of age and less than 18 years of age?	☐ 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 ____________