

Prior Authorization Request Form for Adlyxin, Byetta, Mounjaro, Ozempic, Victoza



6103

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) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

- The provider may **call: 1-866-684-4488**
or the completed form may be **faxed to:**
1-866-684-4477

- The patient may attach the completed form
to the prescription and **mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
or **email** the form only to:
TPharmPA@express-scripts.com

Step 1 Please complete patient and physician information (please print):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. What is the requested medication?	<input type="checkbox"/> Ozempic - Proceed to question 2 <input type="checkbox"/> Victoza - Proceed to question 2 <input type="checkbox"/> Adlyxin - Proceed to question 3 <input type="checkbox"/> Byetta - Proceed to question 3 <input type="checkbox"/> Mounjaro- Proceed to question 2		
2. Is Ozempic, Victoza, or Mounjaro being used for weight loss?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> Yes STOP Coverage not approved </td> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> No Proceed to question 3 </td> </tr> </table>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 3
<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 3		
3. Does the patient have a diagnosis of type 2 diabetes mellitus?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> Yes Proceed to question 4 </td> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> No STOP Coverage not approved </td> </tr> </table>	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved		
4. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> Yes Proceed to question 7 </td> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> No Proceed to question 5 </td> </tr> </table>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 5
<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 5		
5. 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?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> Yes Proceed to question 7 </td> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> No Proceed to question 6 </td> </tr> </table>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 6
<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 6		
6. Does the patient have a contraindication to metformin?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> Yes Proceed to question 7 </td> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> No STOP Coverage not approved </td> </tr> </table>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved		
7. Has the patient had an inadequate response with Bydureon BCise?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> Yes Proceed to question 9 </td> <td style="width: 50%; text-align: center; padding: 5px;"> <input type="checkbox"/> No Proceed to question 8 </td> </tr> </table>	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 8
<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 8		

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8. Is the patient unable to take Bydureon BCise due to impaired renal function?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Has the patient had an inadequate response with Trulicity?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[15 June 2022]