

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

VICTOZA (liraglutide)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Minimum age requirement: 17 years old.
- **Not using insulin except for Lantus (insulin glargine).**
- Using Victoza as adjunct therapy in patient with Type II diabetes
- Not using Victoza as a substitute for insulin
- Not in end-stage renal disease
- Not on dialysis
- Not diagnosed with gastroparesis
- Information showing lack of glycemic control, indicated by A1C > 7 (fax a copy of lab work, or provide a A1C value, test date, and provider signature)
- Receiving the following concurrent therapies:
 - Metformin, a sulfoneura (**identify by name**) or both
--- **OR** ---
 - TZD (>glitazone= - **identify by name**) alone or in combination with metformin

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Written request from physician showing patient is stable on Victoza and patient is not on insulin

04/24/2012

<http://health.utah.gov/medicaid/pharmacy>