REALRx

# PRIOR AUTHORIZATION REQUEST FORM

## MOUNJARO and GLP-1s

Bydureon®, Ozempic®, Rybelsus®, Trulicity®, and Victoza®

**For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|---|---|---|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |

Height/Weight:

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Preferred:**

☐Bydureon® (exenatide), ☐ Ozempic® (semaglutide), ☐ Rybelsus®(semaglutide), ☐ Trulicity®(dulaglutide), and ☐ Victoza®(liraglutide), ☐ Mounjaro®(tirzapatide)

Dosing/Frequency:_____

**If the request is for reauthorization, proceed to reauthorization section.**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| 1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy. | ☐ | ☐ | |
| 2. Does the requested member have a diagnosis of type 2 diabetes? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the member tried and failed generic metformin or a generic metformin-containing combination for at least 3 months? | ☐ | ☐ | |
| **REAUTHORIZATION** | | | |
| 1. Is the request for reauthorization of therapy? | ☐ | ☐ | |
| 2. Does the member show a continued medical need for the therapy? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the therapy been tolerable and effective? | ☐ | ☐ | **Please provide documentation** |

**What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.**

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|---|
| Additional information: |
| Physician Signature: |

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM- 148
Origination Date: 01/11/2023
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023