MHLA Liraglutide (Victoza®) Prior Authorization Form

Instructions

1. Please fill out all sections of the form on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes, lab data, to support the PA request. Incomplete forms will be filed as incomplete.
2. Submit complete form along with complete documents via Email: priorauth@dhs.lacounty.gov or Fax: 310-669-5609

Notes

1. Authorizations are limited to a maximum of **twelve (12) months** of therapy. Additional authorization is required for any use after this initial 12-month period.
2. Please complete **ALL** areas below, as incomplete prior authorization requests **MAY AFFECT THE OUTCOME** of this request.

Patient Information: This must be filled out COMPLETELY to ensure HIPAA compliance					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		CA	Zip Code:	
Date of Birth:	☐ Male ☐ Female	Height:	Weight:	Allergies:	
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:			
Insurance/Coverage Information					
Primary Insurance/Coverage Name: **My Health LA**		MHLA Patient ID Number:			
Prescriber Information					
First Name:	Last Name:		Specialty:		
Address:	City:		CA	Zip Code:	
Requestor (if different than prescriber):		Office Contact Person:			
NPI Number (individual):		Phone Number:			
DEA Number (if required):		Fax Number (in HIPAA compliant area):			
Email Address:					
Victoza® Prescription Information					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:		Quantity:	
☐ New Therapy ☐ Renewal					
If Renewal: Date Therapy Initiated:		Duration of Therapy (specific dates):			
How did the patient receive the medication? ☐ Patient Assistance Program. If PAP denied, please attach denial letter. ☐ Other (explain): _____					

Medication History for This Condition		
Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

LA County DHS P&T Committee Approved: 6/2021

MHLA Liraglutide (Victoza®) Prior Authorization Form Continued

Patient Name:	MHLA Patient ID#:

STEP 1: EXCLUSION CRITERIA *(If any of the following criteria apply, the patient does **NOT** qualify for exenatide use)*

Patient diagnosed with Type 1 Diabetes	Patient has severe gastrointestinal disease, including gastroparesis
Patient with a personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)	Patient has known hypersensitivity to liraglutide or any of the product components
Patient has a history of pancreatitis	Patient on concurrent dipeptidyl peptidase (DPP-4) inhibitor therapy
Patient currently admitted for inpatient care	Patient on concurrent sodium/glucose cotransporter 2 (SGLT2) inhibitor therapy

☐ Patient has no exclusion criteria listed above

STEP 2a: APPROVAL CRITERIA for DM2 with CAD *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval. **None** of the exclusion criteria above apply.)*

Note: Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐ Diagnosis of Type 2 Diabetes with a history of coronary artery disease

☐ Patient on Metformin or has contraindication/intolerance to Metformin and requires add-on of liraglutide for cardiovascular protection with contraindication/intolerance to empagliflozin (Jardiance)

STEP 2b: APPROVAL CRITERIA FOR DM2 without CAD *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval. **None** of the exclusion criteria above apply.)*

Note: Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐ New Therapy; HbA1c greater than or equal to 8% **OR** ☐ Continuation of therapy; HbA1c **MUST BE** less than 8%

☐ Diagnosis of Type 2 Diabetes

☐ Patient has an A1c ≥ 8% at initiation of therapy; A1c < 8% as continuation of therapy.
Patient's current A1c _____ Date _____

☐ Patient has failed or is intolerant/contraindicated to maximal doses of metformin + sulfonylurea + thiazolidinedione AND is contraindicated/intolerant to empagliflozin (Jardiance), please specify on previous page in the medication history section

STEP 3: DOSAGE *(Check the appropriate dosage)*

☐ 0.6 mg subcutaneously daily x 1 week, then increase to 1.2 mg subcutaneously daily	☐ 1.2 mg subcutaneously daily	☐ 1.8 mg subcutaneously daily

STEP 4: ADDITIONAL EXPLANATION *(For additional comments, please attach to form)*

STEP 5: ATTACH RELEVANT PROGRESS NOTE, LABS, and CURRENT MEDS *(Required)*

STEP 6: PRESCRIBER SIGNATURE

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**: _____

Plan Use Only:

Pharmacy Review: Approval criteria met? ☐ **YES** ☐ **NO**
See instructions at top of form for next step following review.

Patient's A1c %:	Date of A1c:
Date Received:	Date of Decision:
Pharmacist Reviewer:	

Medical Review: ☐ **Approved** ☐ **Denied**

Date Received:	Date of Decision:
CMO or Designee:	

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