Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Xultophy® (insulin degludec/liraglutide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Xultophy 100/3.6 (100 units/mL insulin degludec / 3.6 mg liraglutdie)

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Patient meets the current prior authorization criteria for a formulary GLP-1 agonist (e.g., Byetta, Bydureon, Adlyxin, Tanzeum, Trulicity, or Victoza) which includes *all* of the following:
   - Diagnosis of type 2 diabetes mellitus (T2DM)
   - Trial and failure, or intolerance to at least 2 *generic* oral antidiabetic agents or insulin after 3 continuous months of receiving maximal daily doses and not achieved adequate glycemic control
   - Hemoglobin A1c less than or equal to 9%, but not less than 7%
   - Age greater than or equal to 18 years
2. Patient will not be using Xultophy in combination with another GLP-1 receptor agonist or basal insulin.

Priority Health Precertification Documentation

A. Does the patient have a current prior authorization approval on file for a formulary GLP-1 agonist (e.g., Byetta, Bydureon, Adlyxin, Tanzeum, Trulicity, or Victoza?

☐ Yes, please skip to question F and G.
☐ No, please answer all remaining questions.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2017
Last reviewed 07/2018

PriorityHealth

B. What condition is this drug being requested for?

☐ Type 2 diabetes
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

C. What *oral* diabetic medications has the patient tried?

☐ Metformin ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Glipizide ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Glimepiride ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Glyburide ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Pioglitazone ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Aloglitin ☐ **Current** ☐ **Discontinued, Reason :**_____ **Duration:** _____
☐ Others: _____
☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____

D. What insulin therapy has the patient tried?

☐ Lantus ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Levemir ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Humalog ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Novolog ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Humulin ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Novolin ☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____
☐ Others: _____
☐ **Current** ☐ **Discontinued, Reason:**_____ **Duration**:_____

E. What is the patient's most recent Hemoglobin A1c?

☐ Date_____ ☐ Result_____
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

F. Will the patient be using Soliqua in combination with another GLP-1 receptor agonist or basal insulin?

☐ No
☐ Yes, *Rationale for use:* _____

G. Does the patient require a daily insulin glargine dose (or equivalent) below 15 units or over 60 units?

☐ No
☐ Yes, *Rationale for use:* _____

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