SCRIPTGUIDERX REQUEST FOR PRIOR AUTHORIZATION

VICTOZA

Prescribing Physician:

Name:______________________________
First Last

Direct Phone #: (_ _ _) _________________

Fax #: (_ _ _) ______________________

Physician specialty: _________________

Patient:

Name:____
First Last

ID#: ____

Phone #: ______________________Client:__________

Birth Date: _ _ - _ _ - _ _ _ _ Sex: ☐ Female ☐ Male

Name and title of person completing form (please print): _______________________________________

Drug name: Strength: Administration Schedule: Length of Therapy: Quantity Requested:

____

Has patient been on this drug and, if yes, for how long at this dosage? _______________________________

Patient's diagnosis requiring the use of this medication: ____

1. Previous history of a medical condition, allergies or other pertinent medical information that necessitates the use of this medication:

____

2. Has the patient been seen by any other provider for this condition? ☐ Yes ☐ No
If so, what was the prescriber's specialty? ____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _

4. Pertinent laboratory test or procedure: (if applicable)

Procedure:	Findings:	Date:
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _

Prescriber's Signature____

Victoza is approved by the FDA as adjunctive therapy to diet and exercise in type 2 diabetes mellitus.

Fax Request to: ScriptGuideRX @ 313-264-0985

For ScriptGuideRX use only	Decision (all authorizations are pending valid eligibility):
Date Received:	
Date Completed:	