GLP-1 Agonists
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ______________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible):	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? ______________**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

United Healthcare Community Plan

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
VICTOZA 1.2MG PER DAY (2 PEN PACK), LIRAGLUTIDE 1.2MG PER DAY (2 PEN PACK), MOUNJARO, OZEMPIC, RYBELSUS	
□ Yes □ No	**Does the patient have type 2 diabetes mellitus confirmed via medical records (i.e., medical documentation confirming type 2 diabetes mellitus, medical claims history) or prescriber attestation?**
□ Yes □ No	**Has the patient had a suboptimal response (i.e., suboptimal glycemic control) to one product, or a combination thereof, from any of the following drugs/classes for 90 days in the past 365 days, as confirmed by submission of medical records?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Metformin □ Metformin combinations □ DPP-4 inhibitors □ DPP-4 inhibitor combinations □ SGLT2 inhibitors □ SGLT2 inhibitor combinations □ Sulfonylureas
□ Yes □ No	**Does the patient have a history of contraindication or intolerance to one product from any of the following drugs/classes?** *(If yes, check which applies and specify contraindication or intolerance)* □ Metformin. ______ □ Metformin combinations. ______ □ DPP-4 inhibitors. ______ □ DPP-4 inhibitor combinations. ______ □ SGLT2 inhibitors. ______ □ SGLT2 inhibitor combinations. ______ □ Sulfonylureas. ______
VICTOZA 1.8MG PER DAY (3 PEN PACK), LIRAGLUTIDE 1.8MG PER DAY (3 PEN PACK)	
□ Yes □ No	**Does the patient have a diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)?** *(DOCUMENTATION REQUIRED)*
□ Yes □ No	**Has the patient had a suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by submission of medical records?** *(DOCUMENTATION REQUIRED)*
□ Yes □ No	**Does the patient have a history of contraindication or intolerance to metformin?** *(If yes, specify contraindication or intolerance)*
□ Yes □ No	**Does the patient have a history of failure to achieve acceptable glycemic control with Victoza 1.2mg per day for 90 days (2 Pen Pack), as confirmed by submission of medical records?** *(DOCUMENTATION REQUIRED)*

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☐ Yes ☐ No	**Does the patient have a diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)?** *(DOCUMENTATION REQUIRED)*
☐ Yes ☐ No	**Has the patient had a suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by submission of medical records?** *(DOCUMENTATION REQUIRED)*
☐ Yes ☐ No	**Does the patient have a history of contraindication or intolerance to metformin?** *(If yes, specify contraindication or intolerance)*
☐ Yes ☐ No	**Has the patient had a suboptimal response (i.e., suboptimal glycemic control) to any of the following, for a minimum of 90 days, as confirmed by submission of medical records?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* ☐ A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus) ☐ Mounjaro
☐ Yes ☐ No	**Does the patient have a history of contraindication or intolerance to any of the following?** *(If yes, check which applies and specify contraindication or intolerance)* ☐ A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus). ________________ ☐ Mounjaro. ________________

Provider Signature: ______________________________ **Date:** ____________________

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