

**Catamaran Prior Authorization Department****Phone: 866-235-3062****Fax: 866-391-7222****Prescriber Information**

Last Name:

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DEA/NPI:

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Phone

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First Name

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Specialty:

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Fax

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Member Information

Last Name:

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Member ID Number

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First Name

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DOB:

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Medication Information:

Drug Name and Strength:

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Diagnosis:

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Quantity and Dosing:

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Duration:

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Victoza (liraglutide) Prior Authorization Criteria**Please complete all applicable questions**

1. Please document ICD-9 code: _____		
2. What is the daily dose of Victoza the patient is currently receiving? _____ _____		
3. Has the patient had a trial of the lower strength (1.2mg) Victoza for 30 days?	Y	N
4. Has compliance been assessed and adherence confirmed?	Y	N
5. Has the patient been unable to meet glucose control treatment goals on lower dose therapy? Please document supporting glucose or A1c value: _____	Y	N

Comments: _____
Information given on this form is accurate as of this date.

Prescriber or Authorized Signature_____
Date_____
Authorized Medical Staff – Name/Title



Catamaran Prior Authorization Department

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Fax: 866-391-7222

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 800-626-0072.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).