Xultophy (insulin degludec; liraglutide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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Revision Date: 08/22/2018
CAT0288 4/1/2021

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Type 2 diabetes □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the patient already taking the requested medication? □ Yes □ No

Has the patient received prior treatment with Soliqua (insulin glargine/lixisenatide)? □ Yes □ No

Was the patient's most recent HgbA1c (within the past 6 months or prior to starting a GLP-1/insulin combination product) 7% or greater? □ Yes □ No
Copy of HgbA1c level required

Has the patient tried or is the patient currently receiving treatment with metformin? □ Yes □ No

Is this patient's estimated GFR less than or equal to 45 mL/min/1.73 m2? □ Yes □ No

Does the patient have advanced liver disease with at least one of the following? □ Yes □ No

If yes, please select:

- □ **Ascites**
- □ **Hepatic encephalopathy**
- □ **Cirrhosis**
- □ **Portal hypertension**

Has treatment with metformin been avoided due to lactic acidosis or elevated liver enzymes? □ Yes □ No

Is the patient currently taking any of the following medications ? □ Yes □ No

- **Kazano (alogliptin/metformin)**
- **Glyxambi (empagliflozin/linagliptin)**
- **Kombiglyze XR (saxagliptin/metformin**
- **Nesina (alogliptin)**
- **Onglyza (saxagliptin)**
- **Januvia (sitagliptin)**
- **Oseni (alogliptin/pioglitazone)**

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- **Janumet/Janumet XR (sitagliptin/metformin)**
- **Tradjenta (linagliptin)**
- **Jentadueto/Jentadueto XR (linagliptin/metformin)**
- **QTERN (dapagloflozin/saxagliptin)**
- **Seglujan (ertugliflozin/sitagliptin)**

If yes, will concomitant therapy with those agents be discontinued? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

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 or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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