

**Physician's Prior Authorization Questionnaire
Victoza®**

Patient:

ID#:

DOB:

Patient Address:

Victoza® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. Does the patient currently have adequate glycemic control? Yes No
3. What is the patient's most recent HbA_{1c} measurement? _____
4. Is the patient currently taking oral antidiabetic medications? Yes No
5. Is the patient currently taking insulin? Yes No

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx