## Trulicity<sup>®</sup> Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			<b>Provider Information</b> (required)				
Member Name:			Provider Name:				
Insurance ID#:			NPI#: Specialty:				
Date of Birth:			Office Phone:				
Street Address:			Office Fax:				
City:	State:	ZIP:	Office Street Address:				
Phone:		-	City:	State:		ZIP:	
Medication Information (required)							
Medication Name:			Strength: Dosage Form:				
			Directions for Use:				
Clinical Information (required)							
1. Does the patient have a diagnosis of Type 2 diabetes mellitus?					🛛 Yes 🖾 No		
2. Has the patient experienced an inadequate treatment response, intolerance or contraindication to metformin?						🗆 Yes 🗖 No	
If yes, please document medication(s) tried, date of trial(s) and reason:							
3. Does the patient require more than four pens or syringes per 28 days (or 12 pens or syringes per 84 days)?						🗆 Yes 🗅 No	

Information on this form is accurate as of this date.

Prescriber's Signature:	Date:

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

<u>Please note</u>: **This request may be denied unless all required information is received.** For more information about the prior authorization process, please contact us at 855-811-2218. Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

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