OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service

Victoza® 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 Informa	ntion (required)	Pr	ovider Info	rmation	(required)	
Member Na	me:		Provider Nam	Provider Name:			
Insurance ID#:			NPI#:	NPI#:		Specialty:	
Date of Birth	h:		Office Phone:	Office Phone:			
Street Addre	ess:		Office Fax:				
City:	State:	ZIP:	Office Street A	Office Street Address:			
Phone:	one:		City:	State:		ZIP:	
		Medication	Information (r	required)			
Medication I	Name:		Strength:			orm:	
			Directions for	Directions for Use:			
			nformation (req	uired)		☐ Yes ☐ No	
1. Does the	e patient have a diagnos	mellitus?	tus?				
metform		·	•	ponse, intolerance or contraindication to s) and reason:			
3. Does the	e patient require more th	an three prefilled pens	s per month?	er month?			
						☐ Yes ☐ No	
		and the state					
	on this form is accurate a r's Signature:	as of this date.		Da	nte:		
1 100011001	o orginataro.						
Ana thana anu	-th		tuind ou failed and/ou		. the mhunicies	m faala ia immantant	
this review?	other comments, diagnoses	, symptoms, medications	tried or failed, and/or a	iny other information	1 the physicial	n feels is important to	
Please note:	This request may be denie For more information about Monday – Friday: 8 a.m. to	the prior authorization proce	ess, please contact us at				

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