Prescriber Criteria Form

Trulicity 2024 PA Fax 5571-A v2 010124.docx
Trulicity (dulaglutide)
Prior Authorization applies only to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Trulicity (dulaglutide).

Drug Name:
Trulicity (dulaglutide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed to reduce the risk of major adverse cardiovascular (CV) events in a patient with type 2 diabetes mellitus who has established CV disease or multiple CV risk factors? [If yes, then skip to question 3.]	Yes	No
2	Is the requested drug being prescribed to improve glycemic control in a patient with type 2 diabetes mellitus?	Yes	No
3	Is the patient 10 years of age or older?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____