



**Neighborhood Health Plan of Rhode Island  
Medical Necessity Form  
Incretin Mimetics  
Byetta® (Exenatide Injection) and Victoza® (liraglutide)**

**Instructions:**

The General laws of the State of RI provide for a “generic first” Pharmacy Benefit for the State’s Managed Medicaid program. Use of brand name drugs is limited to specific “exempt” drug classes and cases where there is documented evidence that the patient has tried and failed therapy with generic drugs. This form is to be used by participating physicians and providers to obtain coverage for a brand name drug when there is evidence that the patient has tried and failed therapy with generic drugs. *Failure to complete this form will result in Neighborhood not paying for the ordered drug and may delay delivery of the drug to your patient.* Please complete this form and fax to: Neighborhood Customer Service at fax # 866-423-0945. To review the entire Neighborhood Formulary, please visit our website at: [http://www.nhpri.org/matriarch/MultiPiecePage.asp\\_Q\\_PageID\\_E\\_356](http://www.nhpri.org/matriarch/MultiPiecePage.asp_Q_PageID_E_356)

Please complete the following information:

<b>Member Name:</b> (required) _____	<b>Member ID Number:</b> (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
<b>Member Date of Birth:</b> (required)    /    /	<b>Member Sex:</b> M    F    (Circle One)										
<b>Prescriber Name:</b> (required) _____	<b>Contact Person at Office:</b> _____										
<b>Office Phone number:</b> (required) (    ) -	<b>Office Fax Number:</b> (required) (    ) -										

Medication requested: (Check One) <input type="checkbox"/> Byetta 5mcg <input type="checkbox"/> Byetta 10mcg <input type="checkbox"/> Victoza 18mg/3ml (2-pak) <input type="checkbox"/> Victoza 18mg/3ml (3-pak)	<b>Approval criteria for an incretin-mimetic requires that a patient fail an adequate trial with a 2 gram per day dose of metformin and at least one other generic antihyperglycemic medication.</b>
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Patient has **failed to achieve an adequate clinical outcome or experienced side effects/intolerance** following a trial of an appropriate dose and duration of therapy with all of the generic and Formulary agents listed below. **Must indicate all generic and Formulary agents tried:**

	Drug	Dose	Date	Inadequate response Yes/No	Intolerance Yes/No	Description of Intolerance
<input type="checkbox"/>	Metformin					
<input type="checkbox"/>	Sulfonylurea Specify _____					
<input type="checkbox"/>	Other generic Specify _____					

Please indicate the patient’s most recent A1C level provide the date drawn:

**Current A1C** \_\_\_\_\_ %      **Test Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**BENEFIT TERMS UPON APPROVAL**

If patient meets criteria, initial approval will be for 3 months subject to future A1C results. A1C should be measured at 0, 24 and 48 weeks and patient compliance verified to determine patient response. Approval for responders will be granted annually based on A1C results.

**All information provided on this form is accurate as of this date.**

Provider Signature \_\_\_\_\_ NPI \_\_\_\_\_ Date \_\_\_\_\_