



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Byetta® (exenatide)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Physician Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic. Id:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please answer the following questions and sign below:

Q1. What is the requested duration of therapy?
3 months or less More than 3 months

Q2. Does the patient have Type II diabetes?
Yes No

Q3. Has the patient failed glycemic control on maximum tolerated doses of either single or combination therapy (Metformin and sulfonylurea and/or thiazolidinedione?) of at least 3 months duration?
Yes No

Q4. Is the Patient currently taking insulin, alpha-glucosidase inhibitors (Precose, Glyset) or D-phenylalanine derivatives (Starlix)?
Yes No

Q5. Has the patient achieved adequate glycemic control with current treatment with a hemoglobin A1c less than 6.5%.
Yes No

Physician Signature

Date