



Prior Authorization Form
Diabetic Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:
(check one)

- Byetta®, Glumetza®, Januvia®, Symlin®, Janumet®

Date, Patient ID#, DOB, Patient Name, Provider NPI, Prescribing Physician, Office Contact, Office Fax #, Office Phone

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1. DIAGNOSIS FOR DRUG REQUESTED:

- Type 1 Diabetes, Type 2 Diabetes, Other (specify)

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Table with columns: Drug Name, Date, Duration

3. PATIENT HISTORY:

- a. Is the patient currently on long-acting insulin therapy?
b. Is the patient currently on short-acting insulin therapy?

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
Document #, Coverage effective date, Processor Initials, Date, M F Rx coverage, Y N, STANDARD - SELECT, LOB, Previous Auth, Y N, Approved, Reviewer Initials, Date