AmeriHealth

## Prior Authorization Form

# Diabetic Agents

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested:
*(check one)*

☐ **Byetta®** ☐ **Symlin®** ☐ **Onglyza®**
☐ **Glumetza®** ☐ **Janumet®**
☐ **Januvia®** ☐ **Prandimet®**

Date: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**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."

| Drug Name | Date | Duration |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**3. PATIENT HISTORY:**

**a.** Is the patient currently on long-acting insulin therapy? ☐ Yes ☐ No ☐ N/A
(*please specify*): _____

**b.** Is the patient currently on short-acting insulin therapy? ☐ Yes ☐ No ☐ N/A
(*please specify*): _____

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

**Internal use only** **Coverage effective date** / /

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____



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