AmeriHealth

Prior Authorization Form

Diabetic Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:
(check one)

☐ **Byetta®** ☐ **Symlin®** ☐ **Glumetza®**
☐ **Prandimet®** ☐ **Victoza®**
☐ **Non-Preferred Insulin (*specify product*)** _____

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."

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*): _____

INSULIN REQUESTS ONLY:

c. Has the patient tried and failed one **Novo Nordisk** preferred insulin?
(must specify product below) ☐ Yes ☐ No

☐ **Novolin N** ☐ **Novolin R** ☐ **Novolin 70/30** ☐ **Novolog** ☐ **Novolog Mix 70/30**

d. Has the patient tried and failed Levemir? ☐ Yes ☐ No ☐ N/A

Please add any other supporting medical information that may be useful in the decision making process including contraindications to medications related to the diagnosis:

_____
_____
_____
_____

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