



Prior Authorization Form

Diabetic Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one)

- Byetta®, Glumetza®, Januvia®, Non-Preferred Insulin, Symlin®, Janumet®, Prandimet®, Onglyza®, Victoza®

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

INSULIN REQUESTS ONLY:

- c. Has the patient tried and failed one Novo Nordisk preferred insulin?
Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog Mix 70/30

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.