



Prior Authorization Form Diabetic Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:
(check one)

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Byetta® | <input type="checkbox"/> Symlin® | <input type="checkbox"/> Glumetza® |
| <input type="checkbox"/> Prandimet® | <input type="checkbox"/> Victoza® | |
| <input type="checkbox"/> Tradjenta® | <input type="checkbox"/> Actoplus Met/Actoplus Met XR | |
| <input type="checkbox"/> 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.