



Please complete ALL information below and fax your request to 1-888-671-5285

Incretin Mimetics Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Type 2 diabetes mellitus	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p>Medication history:</p> <p>Select the medication(s) the patient has a trial and failure, intolerance or contraindication to:</p> <input type="checkbox"/> Glipizide-metformin <input type="checkbox"/> Glyburide-metformin <input type="checkbox"/> Metformin <input type="checkbox"/> Metformin extended-release (ER) <input type="checkbox"/> Pioglitazone-metformin <p>For Adlyxin requests, in addition to the above, select the medication(s) the patient has a trial and failure or intolerance to:</p> <input type="checkbox"/> Bydureon <input type="checkbox"/> Bydureon BCise <input type="checkbox"/> Byetta <input type="checkbox"/> Ozempic <input type="checkbox"/> Trulicity <input type="checkbox"/> Victoza

<p>Quantity limit requests:</p> <p>What is the quantity requested per MONTH? _____</p> <p>What is the reason for exceeding the plan limitations?</p> <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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