



**Independence
Blue Cross**

**Prior Authorization Form
Diabetic Agents**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:
(check one)

- Byetta®** (exenatide)
- Glumetza®** (metformin ER)
- Januvia®** (sitagliptin)
- Symlin®** (pramlintide)
- Janumet®** (sitagliptin/metformin)

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 _____