



**Independence
Blue Cross**

**Prior Authorization Form
Diabetic Agents**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:
(check one)

- Byetta®
- Glumetza®
- Januvia®

- Symlin®
- Janumet®
- Prandimet®

Onglyza®

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 / /
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M F Rx coverage Y N	STANDARD - SELECT LOB _____
Previous Auth Y N	Approved Reviewer Initials _____ Date _____