



**Independence  
Blue Cross**

**Prior Authorization Form  
Diabetic Agents**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested:  
(check one)

- Byetta®
- Prandimet®
- Non-Preferred Insulin (specify product) \_\_\_\_\_
- Symlin®
- Victoza®
- Glumetza®

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): \_\_\_\_\_

**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.**