

US Family Health Plan Prior Authorization Request Form for Byetta (exenatide)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program (USFHP).

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 OR The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at:
http://www.usfamilyhealth.org/f-downloadable_forms.html This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID: _____	Phone #: _____
Date of Birth: _____	Secure Fax: _____

Step 2 Please complete the clinical assessment:

1. Does the patient have a diagnosis of type 2 diabetes mellitus?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Coverage not approved
2. Has the patient tried at least ONE of the following and failed to achieve glycemic control: METFORMIN (alone or in combination) or a SULFONYLUREA (alone or in combination)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 5
5. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is correct and accurate to the best of my knowledge. Please sign and date

Prescriber Signature

Date

Latest revision: May 2011