



DATE _____

CLIENT _____

PRIOR AUTHORIZATION QUESTIONNAIRE-Byetta® (exenatide) injection

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL****

PA CRITERIA FOR APPROVAL

- Diagnosis:
 - Type 2 diabetes mellitus (ICD-9 code: 250.xx)
 - Other (please specify): _____
- Indicate all that apply to the patient:
 - Known hypersensitivity to Byetta or any of its components
 - Acute pancreatitis or history of pancreatitis
 - ESRD or severe renal impairment (CrCl < 30 mL/min)
 - Gastroparesis or other severe gastrointestinal disease
- Is the patient currently using any of the following? (Please **circle** all that apply)

Glyset Insulin Janumet Januvia Onglyza Prandin Precose Starlix Symlin

 - If the patient is using any of the above medication(s) will the medication(s) be discontinued within the next 90 days?

	Yes	No
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- Continuation of Therapy:**
 - Has the patient experienced improved glycemic control with Byetta therapy?

	Yes	No
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 - Has the patient tried and failed metformin?

	Yes	No
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 - If Yes, provide dates of trial _____
 - If No, provide the rationale for non-trial _____
- Provide the most current HbA1c: _____% Date: _____ (within the year)
- Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
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QUESTIONS PLEASE CALL:
877-526-9906

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