

DATE \_\_\_\_\_



### PRIOR AUTHORIZATION QUESTIONNAIRE-Byetta® (exenatide) injection

<b>M.D. Last Name:</b> _____	<b>M.D. First Name:</b> _____
<b>Physician Phone:</b> _____	<b>Physician Fax:</b> _____
<b>Patient</b> _____	<b>ID#</b> _____ <b>DOB</b> _____

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

1. Diagnosis:
  - Type 2 diabetes mellitus (ICD-9 code: 250.xx)
  - Other (please specify): \_\_\_\_\_
  
2. 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
  
3. Is the patient currently using any of the following? (Please **circle** all that apply)
 

Glyset    Insulin    Janumet    Januvia    Onglyza    Prandin    Precose    Starlix    Symlin

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

	Yes	No
--	-----	----
  
4. **Continuation of Therapy:**

Has the patient experienced improved glycemic control with Byetta therapy?
 

	Yes	No
--	-----	----
  
5. Has the patient tried and failed metformin?
 

	Yes	No
--	-----	----

  - a. If Yes, provide dates of trial \_\_\_\_\_
  - b. If No, provide the rationale for non-trial \_\_\_\_\_
  
6. Provide the most current HbA1c: \_\_\_\_\_%    Date: \_\_\_\_\_ (within the year)
  
7. Physician Signature or name of person providing answers \_\_\_\_\_

**Physician Comments** \_\_\_\_\_

**FAX completed form to:**  
**877-329-7279**

**QUESTIONS:**  
**877-526-9906**