UnitedHealthcare Community Plan

BYETTA / VICTOZA

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐ Yes ☐ No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 CODE:**

Which of the following diagnoses does this member have:

☐ **Diabetes Type I** ☐ **Diabetes Type II** ☐ **Other (Please Specify) _____**

Will the member take any of the following medications along with Byetta or Victoza? (Check all that apply)

☐ **Glyset** ☐ **Aracarbose** ☐ **Starlix**

☐ **Prandin** ☐ **Insulin (specify type) _____**

Other Medications tried PREVIOUSLY *(please provide complete documentation)*

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Additional Clinical information to support this request: _____

_____

*****FOR REAUTHORIZATION REQUESTS ONLY*****

Has the patient's glycemic control improved as evidenced by a decrease in the HbA1c level? Yes or No (circle answer) If yes, please provide current HbA1c and date drawn:

HbA1c_____ Date Drawn: _____

Physician Signature: _____ Date: _____