

# BYETTA / VICTOZA

## PRIOR AUTHORIZATION REQUEST FORM

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

Today's Date _____				
<b>SECTION A - PATIENT INFORMATION</b>				
First Name:		Last Name:		Member ID:
Address: _____				
City:		State:		Zip:
Phone:		DOB:		Allergies:
Primary Insurance:		Policy #:		Group #:
Is the requested medication <b>NEW</b> <input type="checkbox"/> or a <b>CONTINUATION of THERAPY</b> <input type="checkbox"/> ? If so, start date: _____				
Is this patient currently hospitalized? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>				
<b>SECTION B - PHYSICIAN INFORMATION</b>				
First Name:		Last Name:		M.D./D.O.
Address:		City:		State: Zip:
Phone:		Fax:		NPI #: Specialty:
Office Contact Name / Fax Attention to: _____				
<b>SECTION C - MEDICAL INFORMATION</b>				
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:				
<input type="checkbox"/> <b>Diabetes Type I</b> <input type="checkbox"/> <b>Diabetes Type II</b> <input type="checkbox"/> <b>Other (Please Specify)</b> _____				
Will the member take any of the following medications along with Byetta or Victoza? (Check all that apply)				
<input type="checkbox"/> <b>Glyset</b> <input type="checkbox"/> <b>Aracarbosc</b> <input type="checkbox"/> <b>Starlix</b> <input type="checkbox"/> <b>Prandin</b> <input type="checkbox"/> <b>Insulin (specify type)</b> _____				
<b>Other Medications tried PREVIOUSLY (please provide complete documentation)</b>				
<u>Medications</u>	<u>Strength</u>	<u>Directions</u>	<u>Dates of Therapy</u>	<u>Reason for failure / discontinuation</u>
Additional Clinical information to support this request: _____				
<b>***FOR REAUTHORIZATION REQUESTS ONLY***</b>				
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:** \_\_\_\_\_

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