



Byetta® (exenatide) Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information call 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
(Please print)
 Office Contact Person: _____ Phone #: (____)____-____ ext ____
 Office Address: _____
 Medication/dose Requested: _____ Fax #: __ (____) ____ - ____
 Expected Duration of Therapy: _____ ICD-9 _____

1. Does the patient have a diagnosis of diabetes mellitus Type 2?	Yes	No
2. Is the patient's hemoglobin A1c between 7.0 and 9.0 mg/dl? Date of Test: _____ Result: _____	Yes	No
3. Has the patient failed to achieve adequate glycemic control on combination therapy?	Yes	No
a. One maximum dose of metformin (2 grams/day)? Current dose of metformin: _____	Yes	No
b. On maximum dose of sulfonylurea? Current dose of sulfonylurea: _____	Yes	No
4. Does the patient have a contraindication to metformin? Explain: _____	Yes	No
5. Does the patient have a contraindication to a sulfonylurea? Explain: _____	Yes	No
6. Is patient currently being treated with any of the following diabetic medications? ____ Insulin ____ Thiazolidinediones (Actos, Avandia, or Avandamet) ____ Meglitinides (Prandin) ____ Alpha-glucosidase inhibitors (Precose or Glyset) ____ D-phenylalanine derivatives (Starlix)	Yes	No

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only:	<input type="checkbox"/> Approved	Length of Approval _____
<input type="checkbox"/> Denied	Reason for Denial _____	
Reviewer's Signature: _____	Date Reviewed: ____/____/____	
Override Entered in <input type="checkbox"/> Caremark <input type="checkbox"/> CCMS for _____	- _____ by _____	
Office Notified on _____	; at _____ am/pm; by _____ spoke to _____	