

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

BYETTA (exenatide)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA

Patient is:

- ▶ age 17 and above
- ▶ **Not using insulin**
- ▶ using Byetta as adjunct therapy in patient with Type II diabetes
- ▶ not using Byetta as a substitute for insulin
- ▶ taking Metformin, a sulfoneura (**identify by name**) or both

OR

- ▶ a TZD ('glitazone' - identify by name) alone or in combination with metformin
- ▶ not in end-stage renal disease
- ▶ not on dialysis
- ▶ not diagnosed with gastroparesis
- ▶ information showing lack of glycemic control, indicated by A1C > 7 (fax a copy of lab work).

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Written request from physician showing patient is stable on Byetta and patient is not on insulin

