



**Prior Authorization Form
Diabetic Agents**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:
(check one)

- Byetta®
- Prandimet®
- Tradjenta®
- Non-Preferred Insulin (specify product) _____
- Symlin®
- Victoza®
- Actoplus Met/Actoplus Met XR
- Glumetza®

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Office Contact: _____
 Office Fax #: _____ Office Phone: _____

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1. DIAGNOSIS FOR DRUG REQUESTED:

- Type 1 Diabetes
- Type 2 Diabetes
- Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. PATIENT HISTORY:

- a. Is the patient currently on long-acting insulin therapy? Yes No N/A
(please specify): _____
- b. Is the patient currently on short-acting insulin therapy? Yes No N/A
(please specify): _____

INSULIN REQUESTS ONLY:

- c. Has the patient tried and failed one Novo Nordisk preferred insulin?
(must specify product below) Yes No
- Novolin N Novolin R Novolin 70/30 Novolog Novolog Mix 70/30

- d. Has the patient tried and failed Levemir? Yes No N/A

Please add any other supporting medical information that may be useful in the decision making process including contraindications to medications related to the diagnosis:

**FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystx.com
 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**