

UPMC HEALTH PLAN

BYETTA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient Age:	Patient DOB:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed (# of units):
Diagnosis: <input type="checkbox"/> Type I Diabetes <input type="checkbox"/> Type II Diabetes <input type="checkbox"/> Other		Expected length of therapy:	
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication		If ongoing, provide date started: _____	
Place of infusion? (Name and Location)	<input type="checkbox"/> Physician's Office: <input type="checkbox"/> Hospital/Facility:	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE If billed via JCODE, please provide the name of provider or vendor that will bill for this drug: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	

Medical History

What is the patient's HbA1C level? _____

What is the patient's postprandial blood glucose level? _____

Will the patient be currently taking any of the following medications?

Metformin	<input type="checkbox"/> Yes <input type="checkbox"/> No
A sulfonylurea (Glipizide, Glyburide, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
A combination of Metformin and a sulfonylurea	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is patient taking any of the following medications:

Alpha-glucosidase inhibitors (Glyset, Precose)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Meglitinides (Prandin, Starlix)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thiazolidinediones (Actos, Avandia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No

History of formulary medications used to treat the above condition

Past/Current Therapy	Date of Therapy Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

