



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 Name, Prescribing Physician, Office Fax #, Patient ID#, DOB, Provider NPI, Office Contact, 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."

Table with 3 columns: Drug Name, Date, Duration

3. PATIENT HISTORY:

- a. Is the patient currently on long-acting insulin therapy?
b. Is the patient currently on short-acting insulin therapy?

INSULIN REQUESTS ONLY:

- c. Has the patient tried and failed one Novo Nordisk preferred insulin?
(must specify product below)
Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog Mix 70/30

- d. Has the patient tried and failed Levemir?

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

Blank lines for additional medical information

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