



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

BYETTA (Exanatide)

Coverage Criteria / Required Medical Information:

- A. The patient is diagnosed as having type-2 diabetes with an HbA1c level > 7%.
- B. The patient has a creatinine clearance of > 30mL/minute or normal kidney function.
- C. The patient has had an inadequate treatment response, intolerance or contraindication to metformin **and** a sulfonylurea medication.
- D. If the patient has received previous Byetta therapy, the patient demonstrated a reduction in HbA1c since initiating Byetta therapy.

Coverage Duration: Plan Year

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

BYETTA		Reason for Request			
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing			Strength/Dosage		
Formulary Alternative(s) Attempted?			Yes:	No:	
Please List Alternative Formulary Drugs					

Comments					
----------	--	--	--	--	--

Physician Signature: _____

Fax Form to 1-866-481-3704