



MHLA Exenatide (Byetta®) Prior Authorization Form



Instructions

1. Please fill out all sections of the form on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes, lab data, to support the PA request. Incomplete forms will be filed as incomplete.
2. Submit complete form along with complete documents via Email: priorauth@dhs.lacounty.gov or Fax: 310-669-5609

Notes

1. Authorizations are limited to a maximum of **twelve (12) months** of therapy.
Additional authorization is required for any use after this initial 12-month period.
2. Please complete **ALL** areas below, as incomplete prior authorization requests **MAY AFFECT THE OUTCOME** of this request.

Patient Information: This must be filled out COMPLETELY to ensure HIPAA compliance					
First Name:		Last Name:		MI:	Phone Number:
Address:			City:	CA	Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	Allergies:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:		
Insurance/Coverage Information					
Primary Insurance/Coverage Name: My Health LA			MHLA Patient ID Number:		
Prescriber Information					
First Name:		Last Name:		Specialty:	
Address:			City:	CA	Zip Code:
Requestor (if different than prescriber):			Office Contact Person:		
NPI Number (individual):			Phone Number:		
DEA Number (if required):			Fax Number (in HIPAA compliant area):		
Email Address:					
Byetta® Prescription Information					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:		Quantity:	
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal					
If Renewal: Date Therapy Initiated:			Duration of Therapy (specific dates):		
How did the patient receive the medication?					
<input type="checkbox"/> Patient Assistance Program. If PAP denied, <u>please attach denial letter.</u> <input type="checkbox"/> Other (explain): _____					
Medication History for This Condition					
Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)		Response/Reason for Failure/Allergy		



MHLA Exenatide (Byetta®) Prior Authorization Form Continued

Patient Name:	MHLA Patient ID#:
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STEP 1: EXCLUSION CRITERIA *(If any of the following criteria apply, the patient does NOT qualify for exenatide use)*

Patient diagnosed with Type 1 Diabetes or for treatment of diabetic ketoacidosis	Patient has severe gastrointestinal disease, including gastroparesis
Patient with a personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)	Patient has known hypersensitivity to exenatide or any of the product components
Patient has a history of pancreatitis	Patient on concurrent dipeptidyl peptidase (DPP-4) inhibitor therapy
History of drug induced immune mediated thrombocytopenia from exenatide products	Patient on concurrent sodium/glucose cotransporter 2 (SGLT2) inhibitor therapy
Patient currently admitted for inpatient care	Pediatric patient - safety and effectiveness has not been established
Patient has severe renal impairment (CrCl <30 mL/min) or end-stage renal disease. Patient's current Scr _____ Date _____ CrCl _____	
<input type="checkbox"/>	Patient has no exclusion criteria listed above

STEP 2: APPROVAL CRITERIA *(Check ALL criteria that apply, ALL lines must be checked for approval. None of the exclusion criteria above apply.)*
Note: Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

<input type="checkbox"/>	New Therapy; HbA1c greater than or equal to 8% OR <input type="checkbox"/> Continuation of therapy; HbA1c MUST BE less than 8%
<input type="checkbox"/>	Diagnosis of Type 2 Diabetes
<input type="checkbox"/>	Patient has an A1c ≥8% at initiation of therapy; A1c < 8% as continuation of therapy. Patient's current A1c _____ Date _____
<input type="checkbox"/>	Patient has failed or is intolerant/contraindicated to maximal doses of metformin + sulfonylurea + thiazolidinedione AND is contraindicated/intolerant to empagliflozin (Jardiance), please specify on previous page in the medication history section **Please note that the formulary preferred GLP-1 agonist Liraglutide (Victoza®) is preferred in patient with high cardiovascular risk

STEP 3: DOSAGE *(Check the appropriate dosage)*

<input type="checkbox"/>	5 mcg subcutaneously twice daily within 60 minutes before the morning and evening meals	<input type="checkbox"/>	10 mcg subcutaneously twice daily within 60 minutes before morning and evening meals
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STEP 4: ADDITIONAL EXPLANATION *(For additional comments, please attach to form)*

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STEP 5: ATTACH RELEVANT PROGRESS NOTE, LABS, and CURRENT MEDS *(Required)***STEP 6: PRESCRIBER SIGNATURE**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan Use Only:

Pharmacy Review: Approval criteria met? <input type="checkbox"/> YES <input type="checkbox"/> NO See instructions at top of form for next step following review.	
Patient's A1c %:	Date of A1c:
Date Received:	Date of Decision:
Pharmacist Reviewer:	
Medical Review:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Date Received:	Date of Decision:
CMO or Designee:	