



Clinical and PDL Non-Preferred Prior Authorization for Incretin Mimetics

Table with 2 columns: Preferred (Bydureon, Byetta, Victoza) and Non-Preferred, Prior Authorization Required (Tanzeum, Trulicity)

Beneficiary Information

Name:
Medicaid ID #:
Date of Birth:

Pharmacy Information

Name:
Medicaid ID #:
NPI #:
Phone #:
Fax #:
Requested Drug:
NDC:

Prescriber Information

Name:
Medicaid ID #:
NPI #:
Phone #:
Fax #:

Initial Clinical Prior Authorization Information (required for some agents)

Does the patient have a diagnosis of type 2 diabetes?
Please provide an HbA1C from within the past 90 days:
Does the patient have a contraindication to oral diabetic agents?
If yes, please provide name(s) of agent(s):
Please list any other diabetic agents the patient is currently taking:

Victoza ONLY Is the patient currently taking the maximum tolerated dose of metformin?

Victoza & Bydureon: Does the patient have a personal or family history of medullary thyroid carcinoma?

Victoza & Bydureon: Does the patient have a history of multiple endocrine neoplasia syndrome type 2?

Renewal Clinical Prior Authorization Information (required for some agents)

Please provide an HbA1C from within the past 90 days:
Has there been an improvement in HbA1C from pre-treatment levels?
If achievement or maintenance of therapeutic HbA1C goal (<=6.5) has not occurred please provide rationale from the prescriber:



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

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PDL Non-Preferred Prior Authorization Information (required for non-preferred agents)

Please check the appropriate box and provide required information to receive the requested non-preferred drug.

Patient has a medical intolerance to preferred drug. Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____

Patient has had an inadequate response to preferred drug. Name of preferred agent patient tried: _____

An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need: _____

Prescriber's Signature: _____ **Date:** _____

The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.

This form will be returned unprocessed if it is not completed in its entirety.