



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

**Exenatide Extended-Release (Bydureon®) Renewal
Prior Authorization Request Form**

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date Of Birth: ____/____/____

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____

Phone number: (____) _____ Fax number: (____) _____

NDC Requesting: _____

Prescribing Physicians Name: _____

Physician Medicaid ID#: _____ Physician NPI#: _____

Phone number: (____) _____ Fax number: (____) _____

PLEASE ANSWER ALL FOLLOWING QUESTIONS:

Please provide current HbA1C. _____ Date ____/____/____

Has there been documented improvement of HbA1C from pretreatment levels? _____

If achievement or maintenance of therapeutic goals (HbA1C \leq 6.5%) not obtained or fluctuation in HbA1C please provide rationale by the prescribing physician: _____

Signature of Physician or Designee: _____ Date: ____/____/____

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**