



Kansas Medical Assistance Program

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

**Exenatide (Byetta®) Initial
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 Physician's Name: _____

Physician Medicaid ID#: _____ Physician NPI#: _____

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

PLEASE ANSWER ALL FOLLOWING QUESTIONS:

Type 2 diabetes? Yes _____ No _____

Initial Byetta® request, please provide HbA1C within 90 days _____ Date ____/____/____

Will Byetta® be used in combination with oral diabetic agent? Yes _____ No _____

Does the patient have a documented contraindication to oral diabetic agents? Yes _____ No _____

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.**