



Kansas Medical Assistance Program

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

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

Physician Medicaid ID#: _____ Physician NPI#: _____

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

PLEASE ANSWER ALL FOLLOWING QUESTIONS:

DIAGNOSIS: Type 1 diabetes? Yes ____ No ____

Type 2 diabetes? Yes ____ No ____

Current HbA1C (within 90 days): _____ Date: ____/____/____

Is patient compliant with Byetta and oral diabetic agents (if indicated)? Yes ____ No ____

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

If achievement or maintenance of therapeutic goals (HbA1C ≤ 6.5%) not obtained or fluctuation in HbA1C has occurred provide rationale by 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.**