



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

**Prior Authorization for Non-Preferred Incretin Mimetics – Bydureon® (exenatide ER)
 Clinical & PDL
 Initial Request**

Preferred	Non-Preferred, Prior Authorization Required
Byetta® (exenatide)	Bydureon® (exenatide ER)

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 #: _____

Clinical Prior authorization Information Required

Type 2 Diabetes? Yes _____ No _____
 Provide HbA1C done in last 90 days _____ Date ____/____/____
 Provide other antidiabetic agent(s) used in previous 30 days? _____
 Does the patient have a history or family history of medullary thyroid carcinoma in past 2 years? Yes _____ No _____
 Does the patient have a history of multiple endocrine neoplasia syndrome type 2 in past 2 years? Yes _____ No _____

PDL Non-Preferred Prior Authorization Information

Please check the appropriate box and provide the 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.**