



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
 Renewal 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

Provide current HbA1C _____ Date ____/____/____
 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 in HbA1C, please provide rationale by prescribing physician _____

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.**