restat
A Dohmen Company

Date _____

PRIOR AUTHORIZATION QUESTIONNAIRE-Byetta® (exenatide) injection

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN A DELAY IN PA PROCESSING****

1. Diagnosis:
   - ☐ Type 2 diabetes mellitus (ICD-9 code: 250.xx)
   - ☐ Other (please specify): _____

2. Indicate all that apply to the patient:
   - ☐ Known hypersensitivity to Byetta or any of its components
   - ☐ Acute pancreatitis or history of pancreatitis
   - ☐ ESRD or severe renal impairment (CrCl < 30 mL/min)
   - ☐ Gastroparesis or other severe gastrointestinal disease

3. Is the patient currently using any of the following? (Please **circle** all that apply)

Glyset Insulin Janumet Januvia Onglyza Tradjenta Prandin Precose Starlix Symlin

   a. If the patient is using any of the above medication(s) will the medication(s) be discontinued within the next 90 days? Yes No

4. **Continuation of Therapy:**
   a. Has the patient experienced improved glycemic control with Byetta therapy? Yes No

   b. If yes, please provide baseline HbA1c:_____% Date: _____

5. Is the patient currently on Bydureon or Victoza therapy? Yes No

   a. If Yes, will Bydureon or Victoza be discontinued if Byetta is approved? Yes No

6. Has the patient tried and failed the maximum therapeutic dose of metformin? Yes No

   a. If Yes, provide dates of trial _____

   b. If no, please provide clinical rationale for non-trial of the maximum therapeutic dose of metformin.

_____

6. Provide the most current HbA1c: _____% Date: _____ (within the year)

7. Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

Restat
11900 W. Lake Park Dr.
Milwaukee, WI 53224

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906

 Date 11/09/2012