

**Request Form for exenatide (Byetta®)**

**Physician Information**

Name: \_\_\_\_\_

# License: \_\_\_\_\_ Physician specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient Information**

**General Information**

Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Address: \_\_\_\_\_

Sex:  M  F \_\_\_\_\_

**Medication requested:**

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

**Medical Information**

Yes  No 1) Patient with type 2 DM who is taking one of the following:  
\_\_\_ metformin  
\_\_\_ sulfonylurea  
\_\_\_ thiazolidinedione  
\_\_\_ metformin + sulfonylurea  
\_\_\_ metformin + thiazolidinedione

Yes  No 4) Patient has end-stage renal disease or CrCl <30ml/min.

Yes  No 5) Patient has severe gastrointestinal disease, including gastroparesis.

Yes  No 6) Patient has type 1 diabetes.

Yes  No 2) Patient is allergic to insulin.

8) Patient's current HbA1c level \_\_\_\_\_

Yes  No 3) Patient has history of frequent or severe nocturnal hypoglycemia with insulin despite multiple attempts with various dosing regimens.

Please provide any medical information which may support approval: (optional)

Physician signature: \_\_\_\_\_

Date: \_\_\_\_\_