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Bydureon[®], Bydureon BCise[®] & Byetta[®] Prior Authorization Request Form (Page 1 of 2) DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Mem		Provider Information (required)					
Member Information (required) Member Name:			Provider Na	Provider Name:			
Insurance ID#:			NPI#:	NPI#: Specialty:			
Date of Birth:			Office Pho	Office Phone:			
Street Address:	Office Fax:	Office Fax:					
City:	State:	ZIP:	Office Stree	Office Street Address:			
Phone:		1	City:	State:		ZIP:	
		Medicatio	on Informatio	n (required)			
Medication Name:	Strength:			orm:			
			Directions	for Use:			
		Climical	lufa wasti an				
4. Describeration			Information	(required)		DV. DN.	
1. Does the patient have a diagnosis of Type 2 diabetes mellitus?						☐ Yes ☐ No	
2. Has the patient experienced an inadequate treatment response, intolerance or contraindication to metformin?						☐ Yes ☐ No	
If yes, please document medication(s) tried, date of trial(s) and reason:							
3. Has the patient demonstrated a failure of, or intolerance to a six-week trial of Victoza AND Ozempic AND Trulicity AND Rybelsus for the given diagnosis?							
If yes, please document medication(s) tried, date of trial(s) and reason:							
						_	
4. Does the patient have a documented contraindication to the listed formulary alternatives (e.g., Victoza, Ozempic, Trulicity, Rybelsus)?						, ☐ Yes ☐ No	
If yes, please document medication(s) and contraindication:							
						_	
5. Has the patient had an adverse reaction to OR would be reasonably expected to have an adverse reaction to a majority (two or more in a class with at least two alternatives or one in a class with only one						□ Yes □ No	
alternative) of the listed formulary agents used for the requested indication (e.g., Victoza, Ozempic,							
Trulicity, Rybelsus)? If yes, please document medication name(s) and adverse reaction(s):							
6. Does the patient have a clinical condition for which there is no listed formulary agent to treat the condition based on published guidelines or clinical literature (e.g., Victoza, Ozempic, Trulicity,							
Rybelsus)?	on published gi	uldelines of clinical i	iterature (e.g., victo	oza, Ozempic, m	uncity,		
If yes, please do							
7. Is the drug being prescribed within the manufacturer's published dosing guidelines or does the dose fall within dosing guidelines found in accepted compendia or current literature (e.g. package insert, AHFS,							
Micromedex, current accepted guidelines, etc.)?						,	

This document – and others if attached – contains information that is privileged, confidential and/or may contain protected health information (PHI). The provider named above is required by applicable law to safeguard PHI. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately. Office use only: Bydureon-BydureonBCise-Byetta_2021Jan

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Information on this form is accurate as of this date.								
Prescribe	er's Signature:	Date:						
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?								
Please note:	This request may be denied unless all required information is							
	For more information about the prior authorization process, places							

For more information about the prior authorization process, please contact us at 855-811-2218. Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern