

Prior Authorization Request Form for Bydureon/Bydureon BCise, Trulicity



JOHNS HOPKINS
M E D I C I N E

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HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Does the patient have a diagnosis of type 2 diabetes mellitus?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Has the patient experienced any of the following adverse events that precludes treatment with metformin: impaired renal function or a history of lactic acidosis?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Does the patient have a contraindication to metformin?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge.

Please sign and date:

_____ Prescriber Signature

_____ Date

[25 July 2018]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: