

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR BYETTA AND SYMLIN**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Byetta and Symlin Completion Instructions, F-00080A.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name and Strength (Check One)

SymlinPen 60     SymlinPen 120     Symlin 5 ml vial     Byetta 5 mcg     Byetta 10 mcg

5. Date Prescription Written

6. Directions for Use

7. Name — Prescriber

8. Prescriber National Provider Identifier

9. Address — Prescriber (Street, City, State, ZIP+4 Code)

10. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION**

Providers are required to complete Section III and either Section III A or III B before signing and dating this form.

11. Diagnosis Code and Description

12. State the member's most current HbA1c.  
\_\_\_\_\_ %

13. Date Member's HbA1c Measured

14. Is the member using the medication for weight loss?     Yes     No

15. Is the member currently using Byetta?     Yes     No

16. Is the member currently using Symlin?     Yes     No

**SECTION III A — CLINICAL INFORMATION FOR BYETTA®**

17. Does the member have a diagnosis of Type II Diabetes?     Yes     No

18. Is the member at least 18 years old?     Yes     No

19. Is the member currently taking a sulfonylurea?     Yes     No

If yes, indicate the drug name, dose, and directions for use in the space provided.

20. Is the member unable to tolerate the maximum dose of a sulfonylurea due to a clinically significant adverse drug reaction?     Yes     No

If yes, indicate the drug name, dose, and adverse reaction in the space provided.

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**SECTION III A — CLINICAL INFORMATION FOR BYETTA® (Continued)**

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21. Has the member failed to achieve adequate glycemic control at the maximum dose of a sulfonyurea?  Yes  No

If yes, indicate the drug, dose, and directions for use in the space provided.

- Glyburide  
dose \_\_\_\_\_ directions for use \_\_\_\_\_
  - Glipizide  
dose \_\_\_\_\_ directions for use \_\_\_\_\_
  - Glimepiride  
dose \_\_\_\_\_ directions for use \_\_\_\_\_
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22. Is the member currently taking metformin?  Yes  No

If yes, indicate the dose and directions for use in the space provided.

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23. Is the member unable to tolerate the maximum dose of metformin due to a clinically significant adverse drug reaction?  Yes  No

If yes, indicate the dose and adverse reaction in the space provided.

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24. Has the member failed to achieve adequate glycemic control at the maximum dose of metformin?  Yes  No

If yes, indicate the dose and directions for use in the space provided.

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25. Is the member currently taking a thiazolidinedione?  Yes  No

If yes, indicate the drug name, dose, and directions for use in the space provided.

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26. Is the member unable to tolerate the maximum dose of a thiazolidinedione due to a clinically significant adverse drug reaction?  Yes  No

If yes, indicate the drug name, dose, and adverse reaction in the space provided.

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27. Has the member failed to achieve adequate glycemic control at the maximum dose of a thiazolidinedione?  Yes  No

If yes, indicate the drug, dose, and directions for use in the space provided.

- Actos  
dose \_\_\_\_\_ directions for use \_\_\_\_\_
  - Avandia  
dose \_\_\_\_\_ directions for use \_\_\_\_\_
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**SECTION III B — CLINICAL INFORMATION FOR SYMLIN<sup>®</sup>**

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28. Is the member taking insulin for Type I Diabetes?  Yes  No
29. Is the member taking insulin for Type II Diabetes?  Yes  No
30. Is the member at least 15 years old?  Yes  No
31. Is the member using an insulin pump?  Yes  No
32. If the member is taking insulin, indicate their regimen in the space provided.
- Insulin type \_\_\_\_\_ Number of Units \_\_\_\_\_ Directions for Use \_\_\_\_\_
- Insulin type \_\_\_\_\_ Number of Units \_\_\_\_\_ Directions for Use \_\_\_\_\_
- Insulin type \_\_\_\_\_ Number of Units \_\_\_\_\_ Directions for Use \_\_\_\_\_
33. Does the member have gastroparesis?  Yes  No
34. Does the member have hypoglycemia unawareness?  Yes  No
35. Has the member required emergency treatment for severe hypoglycemia in the past six months?  Yes  No
- If yes, how many times?
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**SECTION IV — AUTHORIZED SIGNATURE**

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| 36. SIGNATURE — Prescriber | 37. Date Signed |
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**SECTION V — ADDITIONAL INFORMATION**

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38. Additional diagnostic and clinical information explaining the need for the drug requested may be included below.
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