**Tanzeum® Prior Authorization Request Form**

**Member Information (required)**

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance ID#:</td>
<td>NPI#:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Office Phone:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Office Fax:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Phone:</td>
<td>City:</td>
</tr>
</tbody>
</table>

**Provider Information (required)**

<table>
<thead>
<tr>
<th>Member Information (required)</th>
<th>Provider Information (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication Information (required)</strong></td>
<td></td>
</tr>
<tr>
<td>Medication Name:</td>
<td>Strength:</td>
</tr>
<tr>
<td>Check if requesting <strong>brand</strong></td>
<td>Directions for Use:</td>
</tr>
<tr>
<td>Check if request is for <strong>continuation of therapy</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Information (required)**

Select the diagnosis below:

- Type 2 diabetes mellitus (adjunct to diet and exercise)
- Other diagnosis: ____________________________

ICD-10 Code(s): ____________________________

Select the medications the patient has a failure, contraindication, or intolerance to:

- Bydureon Bcise
- Bydureon Pen
- Bydureon vial
- Byetta
- Metformin
- Metformin extended-release (ER) (generic Fortamet)
- Metformin ER (generic Glucophage XR)
- Metformin ER (generic Glumetza)
- Riomet
- Trulicity
- Victoza

**Quantity limit requests:**

What is the quantity requested per MONTH? ______

**What is the reason for exceeding the plan limitations?**

- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify:** ____________________________
- Other: ____________________________

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 received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.