

**BYETTA®**  
**PREAUTHORIZATION REQUEST**  
**PHYSICIAN FAX FORM**



**ONLY the prescriber may complete and fax this form.**

**Incomplete forms will be returned for additional information.** The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit [www.bcbsil.com](http://www.bcbsil.com)

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

**INSURANCE INFORMATION**

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis: \_\_\_\_\_

Medication Requested: \_\_\_\_\_

1. Is the patient currently treated with the requested medication? .....  Yes  No  
 If yes, when was treatment with the requested medication started? \_\_\_\_\_

2. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Is the patient currently treated with an insulin product? .....  Yes  No

4. Please list all other medications the patient is **currently taking for treatment of this diagnosis.** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis.** (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please fax or mail this form to:**  
 Blue Cross and Blue Shield of Illinois  
 c/o Prime Therapeutics LLC, Clinical Review Department  
 1020 Discovery Road, No. 100  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130      Phone: 800.285.9426**

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