

GLP-1 RECEPTOR AGONISTS

BYETTA[®]/VICTOZA[®]

PHYSICIAN FAX FORM



BlueCross BlueShield
of Illinois

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

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 - ICD-9 code plus description: _____	
Medication Requested: _____	Strength: _____
Dosing Schedule: _____	Quantity per Month: _____
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____	
2. Patient is currently receiving or has tried and failed: Actos [®] , ActoplusMet [®] <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date _____ Glucovance [®] <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date _____ Avandamet, Avandryl, Avandia [®] <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date _____ Metaglip [®] <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date _____ Duetact [®] <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date _____ sulfonylurea (include name) _____ Metformin/ (Glucophage [®] (XR) Glumetza [®] , Riomet [®] , Fortamet [®]) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date _____	
3. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____ _____	
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
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 800.285.9426

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