

**Tradjenta / Jentaduetto**

**PRIOR AUTHORIZATION REQUEST FORM**

**Complete ENTIRE form and Fax to: 866-940-7328**

**SECTION A - PATIENT INFORMATION**

Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW  or a CONTINUATION of THERAPY ? If so, start date: \_\_\_\_\_

Is this patient currently hospitalized? Yes No

**SECTION B - PHYSICIAN INFORMATION**

First Name:	Last Name:			M.D./D.O.
Address:	City:	State:	Zip:	
Phone:	Fax:	NPI #:	Specialty:	

Office Contact Name / Fax Attention to:

**SECTION C - MEDICATION INFORMATION**

<b>Medication:</b>	<b>Strength:</b>
<b>Directions for use:</b>	
<b>Diagnosis</b> (Please be specific & provide as much information as possible):	<b>ICD 10 Code:</b>

**Does the patient have a diagnosis of type 2 diabetes mellitus?** YES NO

**Has the patient tried and failed any of the following? (check any that apply)**

- Metformin/metformin ER (eg, Glucophage, Glucophage XR)
- Sulfonylurea [eg, Amaryl (glimepiride), Diabeta (glyburide), Glucotrol (glipizide)]
- Thiazolidinedione (TZD) [eg, Actos (pioglitazone), Avandia (rosiglitazone)]
- Insulin [eg, Humalog, Humulin, Novolin, Novolog, Lantus]
- Byetta (exenatide)

**For any that are checked please provide dates of therapy and reason for discontinuation:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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