Neighborhood Health Plan of Rhode Island
Medical Necessity Form
Byetta® (Exenatide Injection)

Date of Request: ____________________

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Byetta® (Exenatide injection). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	**Member ID Number:** (required)
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)

Prescriber Name: (required)	**Contact Person at Office:**
Office Phone number: (required) ( ) -	**Office Fax Number:** (required) ( ) -

ASSESSMENT OF BENEFIT NEED:

	YES	NO
1. Patient is diagnosed with inadequate glucose control (A1C ≥ 8.5 %) not previously controlled with metformin and/or a sulfonylurea.	☐	☐
2. Is this patient currently taking *both* metformin and a sulfonyurea?	☐	☐
3. This patient is not candidate for addition of a thiazolidinedione or insulin therapy.	☐	☐
4. Patient is ≥ 18 years of age	☐	☐
5. Please indicate the patient's most recent A1C level in the box at the right and provide the date of diabetes therapy initiation and the most recent AIC test below and: **Therapy Start Date:** _____/_____/____ **Test Date:** ____/____/____	**A1C %:**	
6. Please check off which of the following medications the patient is currently taking		
Glimepiride (Amaryl)	☐	
Chlorpropamide (Diabinese)	☐	
Glipizide (Glucotrol)	☐	
Glipizide XL (Glucotrol XL)	☐	
Glipizide-Metformin HCL (Metaglip)	☐	
Glyburide (Diabeta / Glynase / Micronase)	☐	
Glyburide-Metformin HCL (Glucovance)	☐	
Metformin HCL (Glucophage)	☐	
Metformin HCL ER (Glucophage XR)	☐	
Repaglinide (Prandin)	☐	
Nateglinide (Starlix)	☐	
7. Prescriber is an Endocrinologist.	☐	☐
8. Patient is compliant with oral diabetic medication regimen.	☐	☐

BENEFIT TERMS UPON APPROVAL:

If patient meets criteria, initial approval will be for 3 months subject to future A1C results. A1C should be measured at 0, 24 and 48 weeks and patient compliance verified to determine patient response. Approval for responders will be granted annually based on A1C results.

All information provided on this form is accurate as of this date.

Provider Signature:______________________NPI_____________ **Date:**_____________

Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945