BlueCross BlueShield of Louisiana
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P.O. Box 98031 • Baton Rouge, Louisiana • 70898-9031

CONFIDENTIAL
PATIENT INFORMATION

DRUG AUTHORIZATION FORM
Diabetic Agents

Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ( )	
BCBSLA Provider Number		Area of Practice/Specialty	Phone Number ( )		

REQUESTED DRUG*

- ☐ **Actoplus Met®**
- ☐ **Actoplus Met® XR**
- ☐ **Actos®**
- ☐ Avandamet®
- ☐ Avandaryl®
- ☐ Avandia®
- ☐ Cycloset®
- ☐ **Duetact®**
- ☐ Fortamet®
- ☐ Glucophage®
- ☐ Glucophage® XR
- ☐ Glumetza®
- ☐ **Janumet®**
- ☐ **Januvia®**
- ☐ **Juvisync®**
- ☐ **Kombiglyze® XR**
- ☐ **Onglyza®®**
- ☐ Riomet®
- ☐ Tradjenta®
- ☐ Other

PAST TREATMENT HISTORY (Check ALL that apply)

- ☐ Avandamet®
- ☐ Actoplus Met®
- ☐ Glucophage®
- ☐ Glucophage® XR
- ☐ Glumetza®
- ☐ Fortamet®
- ☐ Riomet®
- ☐ Glucovance®
- ☐ Metaglip®
- ☐ Janumet®
- ☐ Juvisync®
- ☐ Prandimet®
- ☐ Metformin tablets
- ☐ Metformin extended-release tablets
- ☐ Metformin/glyburide
- ☐ Metformin/glipizide
- ☐ Tradjenta®
- ☐ Other___________________

OTHER CLINICAL INFORMATION (Check ALL that apply)

- ☐ Yes ☐ No Does the patient have renal insufficiency or renal disease?
- ☐ Yes ☐ No Does the patient have cardiomyopathy, heart failure, unstable angina or has experienced a myocardial infarction?
- ☐ Yes ☐ No Does the patient have a condition that could potentially increase the risk of hypoperfusion, hypoxemia or dehydration?
- ☐ Yes ☐ No Is the patient alcohol dependent or does the patient have hepatic impairment?
- ☐ Yes ☐ No Is the patient unable to swallow or has difficulty swallowing tablets?
- ☐ Yes ☐ No Does the patient have chronic metabolic acidosis?
- ☐ Yes ☐ No Is the patient initializing combination therapy with Januvia® + metformin OR Onglyza® + metformin?
- ☐ Yes ☐ No Is there clinical evidence or patient history that suggests the step 1 medication will be ineffective or cause an adverse reaction to the patient? ____

PHYSICIAN SIGNATURE ______________________________ **Prescribing Physician**	DATE ______________________

*Preferred brand drugs (Tier 2) are designated in bold.
Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed