California ADAP Access Form for Rosiglitazone (Avandia®) Use in Type 2 Diabetes
TELEPHONE: 888-311-7632 FAX: 800-848-4241

After considering the available data on the cardiovascular risks of rosiglitazone (**(Avandia®)** the FDA has decided to place all products containing rosiglitazone (Avandia ®, Avandaryl ™ and Avadamet ™) under patient informed consent requirements for continued or initiation of therapy with these medication. The CA ADAP Medical Advisory Committee has determined that CA ADAP will continue to cover rosiglitazone **(Avandia®) by prior authorization ONLY.** Only one submission is required per patient

Complete the appropriate section listed below for determination of treatment authorization

Section 1: Patient Information

Patient Name_____ ADAP ID #: _____
Last Name First Name

Patient DOB_____

Section 2. Rosiglitazone (Avandia®) access for existing ADAP clients newly initiating rosiglitazone and for ADAP clients who previously received rosiglitazone through another payer (i.e. Medi-Cal, Medicare Part D or Private Payer). All three criteria must be met

YES NO

☐ ☐ 1. This patient has signed an informed consent form according to the published FDA guidelines on the use of rosiglitazone. A copy of the client signed informed consent has been faxed along with this prior authorization form.

☐ ☐ 2. Patient is unable to achieve glycemic control on other medications and after consultation with their physician decides not to take pioglitazone (Actos®) for medical reason(s).

☐ ☐ 3. Prescriber has exhausted all other diabetic therapies and there is a documented lack of alternatives for this patient. A list of failed therapies has been faxed with this prior authorization.

Section 3. Rosiglitazone (Avandia®) access for ADAP clients continuing treatment

Complete this section if patient is currently taking rosiglitazone. Both conditions must be met

YES NO

☐ ☐ 1. This patient has signed an informed consent form according to the recently published FDA guidelines on use of rosiglitazone. A copy of the client signed informed consent has been faxed along with this prior authorization form.

☐ ☐ 2. Prescriber has exhausted other diabetic therapies and there is a documented lack of alternatives for this patient. A list of failed therapies has been faxed with this prior authorization.

DATE:	To the best of my knowledge, I certify that the above is accurate and true.	
Prescriber Name	Prescriber Signature	
Phone #	Fax #	DEA #
Pharmacy Name	NABP/NPI #	
Phone #	Fax #	