FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

REQUEST FOR PRIOR AUTHORIZATION

Amylino Mimetic (Symlin®)

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___| Patient Name: ______________________________ DOB: ______________

Patient Address:____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_________________________ Phone:______________

Prescriber Address:____ Fax:_________________

Pharmacy Name:________________________ Address:_________________________________ Phone:______________

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy
NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _________________ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for amylino mimetics (Symlin®). Payment will be considered under the following conditions: 1) Diagnosis of Type 1 or Type 2 diabetes mellitus, 2) Concurrent use of insulin therapy, 3) Documentation of blood glucose monitoring three or more times daily, 4) Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regiments. Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period. **Preferred**

Symlin® ☐

Strength	Dosage Instructions	Quantity	Days Supply
______	__________________	_______	_______

Diagnosis: ______________________________________

Concurrent mealtime insulin therapy to be used with Symlin®: Insulin Product Name: _________________________

Trial start date: ____________ Dose: ________________

Patient is monitoring blood glucose levels three or more times/day: ☐ Yes ☐ No Documentation of inadequate glycemic control with mealtime insulin therapy:

Insulin Product Name: __________________________________

Trial start date: ____________ Trial end date: _______________ Reason for failure: _____________________

____

Most recent HbgA1C Level:________________ Date HbgA1C was obtained:___________________________

Other relevant information:____

Attach lab results and other documentation as necessary.

Prescriber Signature: ____________________________________ Date of Submission: ___________________
***MUST MATCH PRESCRIBER LISTED ABOVE**

***IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*

Rev. 4/19