

SYMLIN
PRIOR AUTHORIZATION FORM

Symlin is a Preferred agent on the Medical Assistance Preferred Drug List (PDL) & requires a clinical prior authorization. To review the prior authorization guidelines, refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Incretin Mimetic/Enhancer Hypoglycemics at: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm>. Symlin is also subject to quantity limits – if the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: <http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information

For Additional Information: Coordinator Name: _____ PA#: _____

Number of Pages in this Request: _____ Office Contact Name: _____ & Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

NPI#: _____ OR MA Provider ID#: _____ State License#: _____

Prescriber Address: _____ Suite #: _____

City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____

MEDICAL INFORMATION

Symlin Dose: _____ **Quantity:** _____ **Refills:** _____

Diagnosis: Type 1 Diabetes Type 2 Diabetes **Diagnosis Code:** _____ (required)

All Initial Requests

1. Document baseline Hemoglobin A1c level: _____ % **Date Taken:** _____ (submit documentation)

2. Check all that apply to the Recipient and submit documentation:

- Recipient is using an insulin pump
- Recipient requires three or more insulin injections per day (please submit documentation of regimen)
- Recipient is compliant with prescribed home blood glucose monitoring
- Recipient has significant day-to-day variability in glucose levels (based on home blood glucose monitoring results)

3. Does the Recipient have any of the following conditions (check any that apply and submit documentation)?

- Hypoglycemia unawareness
- Recurrent severe hypoglycemia requiring medical intervention during the past 6 months
- Gastroparesis and/or taking a medication to stimulate gastrointestinal motility

4. If diagnosis is Type 2 Diabetes: Has the Recipient failed to achieve glycemic control with maximum tolerated doses of metformin, or have a contraindication or intolerance to metformin? Yes – submit documentation No

All Renewal Requests

1. Document the following Hemoglobin A1c levels and submit documentation:

(a) Baseline: _____ % **Date Taken:** _____

(b) Most Recent (if applicable): _____ % **Date Taken:** _____

2. Since Symlin was last approved, have there been any changes to the Recipient's diabetic treatment regimen (e.g., dosage or medication changes)? Yes – submit documentation No

3. Has the Recipient been compliant with prescribed home blood glucose monitoring? Yes – submit documentation No

4. Has the Recipient experienced any of the following while on Symlin (check any that apply and submit documentation)?

- Hypoglycemia unawareness
- Recurrent unexplained hypoglycemia requiring medical intervention
- Persistent clinically significant nausea or abdominal pain

PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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