

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SYMLIN (pramlintide)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX THE FOLLOWING INFORMATION FROM PROGRESS NOTES OR IN A LETTER OF MEDICAL NECESSITY TO 855-828-4992 note the new fax number

CRITERIA:

- Is being used for Type 1 or Type 2 adjunct therapy for patient who uses mealtime insulin.
- Patient has failed desired glucose control despite optimal insulin therapy
- Patient does not have gastroparesis or hypoglycemia
- Is insulin compliant
- Does regular insulin monitoring
- Has HbA less than 9%
- Has not had a hypoglycemic incident requiring assistance in the past 6 months

AUTHORIZATION:

1 Year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/20/10