AmeriHealth Caritas New Hampshire

Symlin® (Pramlinitide Acetate)

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history
1. Does the patient have a diagnosis of Type 1 diabetes? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Type 2 diabetes? ☐ Yes ☐ No
3. Is the patient 18 years of age or older? ☐ Yes ☐ No
4. Does the patient have a HgA1C level greater than 9%? ☐ Yes ☐ No _____ %
5. Does the patient have a confirmed diagnosis of gastroparesis or is the patient currently taking medications to stimulate GI motility? ☐ Yes ☐ No
6. Does the patient require insulin therapy? ☐ Yes ☐ No
7. For Type 2 Diabetics Only: Has the patient tried and failed to attain adequate glycemic control on maximum tolerated dose of metformin? ☐ Yes ☐ No
8. Has the patient experienced severe recurrent hypoglycemia in the last 6 months? ☐ Yes ☐ No
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.