



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Symlin® (pramlintide)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	Physician Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic. Id:
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the duration of the therapy requested? 3 months or less More than 3 months
Q2. What is the patient's age? Less than 18 years Equal to or greater than 18 years
Q3. What is the patient's diagnosis? Type I diabetes Type II diabetes Other
Q4. If Other, Please specify:
Q5. Has the patient failed to achieve adequate glycemic control despite individualized insulin management? Yes No
Q6. Before initiating therapy, has the patient's Hemoglobin A1C, recent blood glucose monitoring data, history of insulin induced hypoglycemia, current insulin regimen, and body weight been reviewed? Yes No
Q7. What is the patient's Hemoglobin A1C ? 9% or less Greater than 9%
Q8. As the prescriber are you;An endocrinologist or a health care provider skilled in the use of insulin and supported by the services of a diabetes educator? Yes No
Q9. Does the patient display any of these behaviors or have any of these contraindicated conditions? (check all that apply) Documented gastroparesis. Use of other drugs affecting GI motility (anticholinergics, such as atropine) or agents that slow the intestinal absorption of nutrients (alpha glucosidase inhibitors). Recurrent severe hypoglycemia requiring assistance during the previous 6 months



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Symlin® (pramlintide)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:

Physician Name:

Presence of hypoglycemia unawareness Poor compliance with current insulin regimen Poor compliance with prescribed self-blood glucose monitoring None of the above
--

Physician Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.