

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SYMLIN (pramlintide)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone # _____

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 (801) 536-0477

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:

Telephone call from pharmacy or doctor's office