pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SYMLIN (pramlintide) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hypoglycemics, Incretin Mimetics/Enhancers (including Symlin)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	☐SymlinPen 60 pen injector	Quantity: _____	Refills: _____
	☐SymlinPen 120 pen injector	Quantity: _____	Refills: _____
Directions:			
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	

INITIAL requests

What is the beneficiary's diagnosis?	☐Type 1 diabetes	☐Type 2 diabetes
What is the beneficiary's most recent hemoglobin A1c?	HbA1c: _____%	Date of test: _____ / _____ / _____
Has the beneficiary failed to achieve adequate glycemic control while adherent with optimal insulin therapy?	☐Yes ☐No	*Submit documentation of insulin regimens tried and outcomes, including HbA1c results.*
Will the beneficiary be using Symlin in addition to insulin? List insulins that will be used: _____ _____	☐Yes ☐No	*Submit documentation of current, complete medication list.*
For a diagnosis of type 2 diabetes, does the beneficiary have a history of failure to achieve glycemic control using maximum tolerated doses of metformin or a contraindication or intolerance to metformin?	☐Yes ☐No	*Submit documentation of HbA1c results and/or contraindications or intolerances.*
For a diagnosis of type 2 diabetes, does the beneficiary have a history of failure to achieve glycemic control with the preferred **Hypoglycemics, Incretin Mimetics** or have a contraindication or intolerance to these medications? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics.*	☐Yes ☐No	*Submit documentation of HbA1c results and/or contraindications or intolerances.*

RENEWAL requests

Since starting Symlin, did the beneficiary experience improved glycemic control?	☐Yes ☐No	*Submit documentation of clinical response.*
What is the beneficiary's most recent hemoglobin A1c (since Symlin was started or last approved)?	HbA1c: _____%	Date of test: _____ / _____ / _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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