Prior Authorization Request

Date of Request ______________________

Symlin – pramlintide acetate

Member Information

Name ______________________
Enrollment / Cardholder ID ______________________
Group / Plan ______________________
Birth Date ______________________
Address ______________________
City State Zip ______________________

Relationship (Circle)

Subscriber **Spouse** **Dependent**

Gender (Circle)

Male **Female**

AGE: ______________________

Practitioner Information

Name ______________________
Agent / Contact Name ______________________
Specialty ______________________
Office / Clinic Name ______________________
Address ______________________
City State Zip ______________________
Phone ( ) -
Fax ( ) -
Email @

Primary Diagnosis Condition / Diagnosis Related – Reason for Request

- List the patient's primary diagnosis:______________________
- What is the patient's HbA1c level:_______________________
- What is the patient's current insulin regimen? Include insulin type and frequency:
  ____
  ____
- Is the patient aware of risk of hypoglycemia and importance of compliance? **Y / N**
- Will the supportive services of a diabetes educator be available to this patient? **Y / N**
- Does the patient have a diagnosis of gastroparesis or require the use of drugs to stimulate gastrointestinal motility? **Y / N**

Strength / Dose / Frequency

Duration of Therapy (Expected)

Formulary Alternatives Attempted/Outcome

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? **Y** **N**

Pharmacy Phone Number

____

Practitioner Signature

Date Received: ______________________
Reviewed By: ______________________
Forwarded To: ______________________

FAX Form to 877-800-5633

HealthTrans Prior Authorization
866-805-1690