



SYMLIN[®] (pramlinitide acetate)
 New Hampshire Medicaid Prior Authorization

Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755



Date of Medication Request: ____ / ____ / ____

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____ / ____ / ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

Section II: Clinical History:

1. Does the patient have a diagnosis of Type 1 diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the patient have a diagnosis of Type 2 diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does the patient have a HgA1C level greater than 9 %? _____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the patient have a confirmed diagnosis of gastroparesis or is patient currently taking medications to stimulate GI motility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the patient require insulin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. <u>For Type 2 Diabetics Only:</u> Has the patient tried and failed to attain adequate glycemic control on maximum tolerated doses of combination therapy of metformin and sulfonylurea? If patient is not a candidate for therapy for one of the agents, then maximum tolerated doses of the individual agents is acceptable.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has the patient experienced severe recurrent hypoglycemia in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.	

Section III: Prescriber Information:

Name: _____	NPI Number: _____
Phone Number: (____) _____ - _____	Fax Number: (____) _____ - _____

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.

Signature of Prescribing Provider