Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Amylino Mimetic (Symlin®)

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

Provider Help Desk
1 (844) 236-1464

FAX Completed Form To
1 (877) 733-3195

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: ______________________ DOB: ____________

Patient Address: ____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name: ____________________ Phone: __________
Prescriber Address: ____________________________________ Fax: ____________

Pharmacy Name: ________________ Address: ____________________ Phone: __________

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy
NPI: | | | | | | | | | | | Pharmacy Fax: NDC : | | | | | | | | | | | | |

Prior authorization is required for amylino mimetics (Symlin®). Payment will be considered under the following conditions: 1) Diagnosis of Type 1 or Type 2 diabetes mellitus, 2) Concurrent use of insulin therapy, 3) Documentation of blood glucose monitoring three or more times daily, 4) Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regiments. Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.

Preferred

Symlin® ☐

Strength	Dosage Instructions	Quantity	Days Supply
________	____________________	________	________

Diagnosis: ______________________________

Concurrent mealtime insulin therapy to be used with Symlin®: Insulin Product Name: ____________________

Trial start date: __________ Dose: ____________

Patient is monitoring blood glucose levels three or more times/day: ☐ Yes ☐ No

Documentation of inadequate glycemic control with mealtime insulin therapy:

Insulin Product Name: ____________________________

Trial start date: __________ Trial end date: ____________ Reason for failure: ________________

Most recent HbgA1C Level: ____________ Date HbgA1C was obtained: ____________________

Other relevant information: ____

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Attach lab results and other documentation as necessary.

Prescriber Signature: ______________________________ Date of Submission: ________________
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.