



Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas Symlin (Pramlintide) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Symlin (Pramlintide) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
SYMLINPEN 60 PEN INJECTOR	SYMLINPEN 120 PEN INJECTOR

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

- Is the requested drug required per court order? (court order required) Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 2.
- Is the patient 18 years of age or older? Y N
If the answer to this question is yes, go to question 3.
If the answer to this question is no, denied.
- Does the patient have a diagnosis of diabetes mellitus in the last 730 days? Y N
If the answer to this question is yes, go to question 4.
If the answer to this question is no, denied.
- Does the patient have a diagnosis of gastroparesis or diabetes with neurological manifestation in the last 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 5.

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| 5. Does the patient have a history of a metoclopramide agent in the last 30 days?
<i>If the answer to this question is yes, denied.</i>
<i>If the answer to this question is no, go to question 6.</i> | Y | N |
| 6. Does the patient have history of an insulin agent in the last 30 days?
<i>If the answer to this question is yes, go to question 7.</i>
<i>If the answer to this question is no, denied.</i> | Y | N |
| 7. Does the patient have a diagnosis of hypoglycemia in the last 180 days?
<i>If the answer to this question is yes, go to question 8.</i>
<i>If the answer to this question is no, go to question 9.</i> | Y | N |
| 8. Does the patient have an ER visit for hypoglycemia in the last 180 days?
<i>If the answer to this question is yes, denied.</i>
<i>If the answer to this question is no, go to question 9.</i> | Y | N |
| 9. Does the patient have a history of an HbA1c test in the last 180 days?
<i>If the answer to this question is yes, go to question 10.</i>
<i>If the answer to this question is no, denied.</i> | Y | N |
| 10. Is the request for a non-preferred drug?
<i>If the answer to this question is yes, go to question 11.</i>
<i>If the answer to this question is no, approved for 365 days.</i> | Y | N |
| 11. Has the patient failed a 14-day treatment trial with at least 1 preferred agent within the last 180 days?
<i>If the answer to this question is yes, approved for 365 days.</i>
<i>If the answer to this question is no, go to question 12.</i> | Y | N |
| 12. Is there a documented allergy or contraindication to preferred agents in this class?
<i>If the answer to this question is yes, approved for 365 days.</i>
<i>If the answer to this question is no, go to question 13.</i> | Y | N |
| 13. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
<i>If the answer to this question is yes, approved for 365 days.</i>
<i>If the answer to this question is no, denied.</i> | Y | N |

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (or Authorized) Signature

Date