Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

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)

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:_____

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.