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New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Symlin® (pramlinitide acetate)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of Type 1 diabetes? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Type 2 diabetes? ☐ Yes ☐ No
3. Is the patient 18 years of age or older? ☐ Yes ☐ No
4. Does the patient have a HgA1C level greater than 9%? % ☐ Yes ☐ No
5. Does the patient have a confirmed diagnosis of gastroparesis or is the patient currently taking medications to stimulate GI motility? ☐ Yes ☐ No
6. Does the patient require insulin therapy? ☐ Yes ☐ No
7. For Type 2 Diabetics Only: Has the patient tried and failed to attain adequate glycemic control on maximum tolerated dose of metformin? ☐ Yes ☐ No
8. Has the patient experienced severe recurrent hypoglycemia in the last 6 months? ☐ Yes ☐ No
9. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

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.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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Effective Date: 12/01/2018

Magellan Rx MANAGEMENT℠