PRIOR AUTHORIZATION REQUEST

Symlin

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

CRITERIA FOR APPROVAL

1	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
2	What is the diagnosis or indication? [] Type 1 or 2 Diabetes Mellitus (If checked, go to 3) [] Other (If checked, no further questions)		

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Medicaid with a Heart

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3	Is this medication being prescribed by, or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
4	Is the patient currently on mealtime bolus insulin (such as Novolog or Humalog)? [If no, no further questions.]	Yes	No
5	Has the patient failed to achieve desired glucose control with optimal insulin therapy? [If no, no further questions.]	Yes	No
6	Does the patient have ANY of the following: A) Hypoglycemia unawareness or recurrent episodes of hypoglycemia, B) Gastroparesis, C) Poorly controlled diabetes (e.g., A1c greater than 9%), D) Poor adherence to current insulin regimen?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250