OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: SymLin® /SymLinPen® (pramlintide acetate) ***(Non-Preferred) (MEDICAID)***

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form: ______________________________ **Strength:** ______________________

Dosing Schedule: __________________________ **Length of Therapy:** _________________

Diagnosis: _______________________________ ***ICD Code, if applicable:*** _______________

CLINICAL CRITERIA (for Injectable Amylin Analogs): ALL boxes must be checked to qualify to ensure authorization process will NOT be delayed.

- ❑ Patient is meeting ***ALL*** of the following criteria ***(and may be approved)***:
  - ❑ Diagnosis of Type 1- or 2- diabetes

    AND
  - ❑ On insulin therapy

    AND
  - ❑ Failure to achieve adequate glycemic control (HbA1c > 6.6%)
- ❑ Patient must have a history of at least a 90-day trial of insulin

Patient Name: ____

Member Optima #: ___________________________ Date of Birth: _______________

Prescriber Name: ____

Prescriber Signature: _________________________ Date: _______________

Office Contact Name: ____

Phone Number: ______________________ Fax Number: ___________________

DEA OR NPI #: ____

REVISED/UPDATED: 7/1/2018