OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 INFORMATON: Complete information below. If incomplete, 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 or authorization process will be delayed.

- ❑ Patient must have a history of at least a 90-day trial of insulin
- ❑ SymLin® is only indicated as adjunct therapy with insulin
- ❑ 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 ≤ 6.5%)

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~6/30/2017;~~ **9/1/2017**;