Pramlintide (Symlin®) Prior Authorization Request Form

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (Please print)

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Does the patient have a confirmed diagnosis of type 1 or type 2 diabetes mellitus ?	☐ Yes Proceed to Question 2	☐ No Coverage not approved
2. Has the patient experienced recurrent severe hypoglycemia requiring assistance within the last 6 months OR is the patient typically unaware of the occurrence of hypoglycemia?	☐ Yes Coverage not approved	☐ No Proceed to Question 3
3. Does the patient have a confirmed diagnosis of gastroparesis or does he/she require the use of drugs to stimulate gastrointestinal motility?	☐ Yes Coverage not approved	☐ No Proceed to Question 4
4. Does the patient have a HbA1c ≤ 9%?	☐ Yes Proceed to Question 5	☐ No Coverage not approved
5. Is the patient currently on mealtime insulin?	☐ Yes Proceed to Question 6	☐ No Coverage not approved
6. Is the patient adherent to their current insulin regimen?	☐ Yes Proceed to Question 7	☐ No Coverage not approved
7. Does the patient regularly and reliably monitor blood glucose levels 3 or more times per day and is the patient capable of monitoring blood glucose levels pre- and post-meals and at bedtime?	☐ Yes Proceed to Question 8	☐ No Coverage not approved
8. Has the patient failed to achieve adequate control of blood glucose levels despite individualized management of insulin therapy?	☐ Yes Proceed to Question 9	☐ No Coverage not approved
9. Is the patient under the guidance of a health care provider skilled in use of insulin and supported by the services of a diabetes educator?	☐ Yes Coverage approved	☐ No Coverage not approved

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ ______________

Prescriber Signature Date

Latest revision: 13 April 2011

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: