

Pramlintide (Symlin[®]) Prior Authorization Request Form



5592

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TpharmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

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:

1. Does the patient have a confirmed diagnosis of type 1 or type 2 diabetes mellitus ?	<input type="checkbox"/> Yes Proceed to Question 2	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Proceed to Question 4
4. Does the patient have a HbA1c ≤ 9%?	<input type="checkbox"/> Yes Proceed to Question 5	<input type="checkbox"/> No Coverage not approved
5. Is the patient currently on mealtime insulin?	<input type="checkbox"/> Yes Proceed to Question 6	<input type="checkbox"/> No Coverage not approved
6. Is the patient adherent to their current insulin regimen?	<input type="checkbox"/> Yes Proceed to Question 7	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to Question 8	<input type="checkbox"/> No Coverage not approved
8. Has the patient failed to achieve adequate control of blood glucose levels despite individualized management of insulin therapy?	<input type="checkbox"/> Yes Proceed to Question 9	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Coverage approved	<input type="checkbox"/> No Coverage not approved

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

_____ Prescriber Signature	_____ Date
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