

US Family Health Plan Pramlintide (Symlin) Prior Authorization Request Form

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) US Family Health Plan pharmacy program (USFHP).

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 OR The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/f-downloadable_forms.html
 This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (Please Print)

1 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 not approved	<input type="checkbox"/> No Coverage not approved

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

3 _____
Prescriber Signature
Date