GHP Family Pharmacy Customer Service
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Geisinger

SYMLIN (pramlintide) PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for Hypoglycemics, Incretin Mimetics/Enhancers (including Symlin) and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Phone number of office contact:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:
- ☐ SymlinPen 60 pen injector — Quantity: ______________ Refills: ________
- ☐ SymlinPen 120 pen injector — Quantity: ______________ Refills: ________

Directions:

Diagnosis (*Submit documentation*):	Dx code (*required*):

INITIAL requests

What is the beneficiary's diagnosis?	☐ Type 1 diabetis ☐ Type 2 diabetis
What is the beneficiary's most recent hemoglobin A1c? HbA1c: ____________%	Date of test: ______ / ______ / ______
For a diagnosis of type 2 diabetes, does the beneficiary have a history of failure to achieve glycemic control using maximum tolerated doses of metformin as evidenced by the beneficiary's HbA1c values	☐ Yes ☐ No
For a diagnosis of type 2 diabetes, does the the beneficiary have a contraindication or intolerance to metformin?	☐ Yes ☐ No — Please list the contraindication or intolerance. ______________
Has the beneficiary failed to achieve adequate glycemic control while adherent with optimal insulin therapy?	☐ Yes ☐ No — *Submit documentation of insulin regimens tried and outcomes, including HbA1c results.*
Will the beneficiary be using Symlin in addition to insulin? List insulins that will be used: ______________________ ______________________	☐ Yes ☐ No — *Submit documentation of current, complete medication list*
Will the beneficiary be using Symlin in addition to a GLP-1 receptor agonist (e.g., Bydureon, Ozempic, Rybelsus, Trulicity, Victoza, etc.) or DPP-4 inhibitor (e.g., Janumet, Januvia, Onglyza, Tradjenta, etc.)?	☐ Yes – *Submit medical literature supporting the concomitant use of these medications* ☐ No

RENEWAL requests

Since starting Symlin, did the beneficiary experience improved glycemic control?	☐ Yes ☐ No — *Submit documentation of clinical response*
What is the beneficiary's most recent hemoglobin A1c (since Symlin was started or last approved)? HbA1c: ____________%	Date of test: ______ / ______ / ______

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date:

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