



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization Drug Approval Form**

Symlin® (pramlintide acetate)

DATE OF MEDICATION REQUEST:     /     /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:  Male  Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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**SECTION III: CLINICAL HISTORY**

- Does the patient have a diagnosis of type 1 diabetes?  Yes  No
- Does the patient have a diagnosis of type 2 diabetes?  Yes  No
- Is the patient 18 years of age or older?  Yes  No
- Does the patient have a HgA1C level greater than 9%?  Yes  No
- Does the patient have a confirmed diagnosis of gastroparesis or is the patient currently taking medications to stimulate GI motility?  Yes  No
- Does the patient require insulin therapy?  Yes  No
- For type 2 diabetics only: Has the patient tried and failed to attain adequate glycemic control on maximum tolerated dose of metformin?  Yes  No

(Form continued on next page.)



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DATE OF MEDICATION REQUEST:    /    /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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**SECTION III: CLINICAL HISTORY (Continued)**

- 8. Has the patient experienced severe recurrent hypoglycemia in the last 6 months?  Yes  No
- 9. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_