UnitedHealthcare Community Plan

SYMLIN/SYMLIN PEN
PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:________________
Is this patient currently hospitalized? □Yes □No

SECTION B - PHYSICIAN INFORMATION

First Name:		Last Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: Strength:

Directions for use:

Diagnosis:	ICD-10 CODE:	Frequency of Administration:

How long has the patient been receiving the requested medication? List the time period: ________________

Is the patient currently using both basal (e.g. Lantus, Levemir) and short-acting (e.g. Novolog, Novolin R) insulin? Yes___ No___

Is the patient receiving three or more insulin injections daily or is on an insulin pump? Yes___ No___

What is the patient's HbA1c? List level:_________

Does the patient currently have OR have a history of ANY of the following:
(Check all that apply)

- ☐ **Exhibited poor compliance with their current insulin regimen**
- ☐ **Recurrent severe hypoglycemia requiring assistance in the past 6 months**
- ☐ **Presence of hypoglycemia unawareness**
- ☐ **Confirmed diagnosis of gastroparesis**
- ☐ **Require the use of drugs that stimulate gastrointestinal motility**
- □ **Less than 15 years of age** **Yes___ No___**

Has the patient had an inadequate response to metformin at a minimum dose of 1500mg daily for 90 days or is unable to receive/tolerate metformin? Yes___ No___

Has the patient had an inadequate response to a thiazolidinedione after 90 days of therapy or is unable to receive tolerate a thiazolidinedione (e.g. Actos)? Yes___ No___

Physician Signature: ____ **Date:** ________________

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