



**Symlin/
Symlinpen**
(pramlintide
acetate)

**Express Scripts
Prior Authorization
Phone (800) 417-8164
Fax 877-837-5922**

Please have the information below ready when calling in the authorization.

Member's Last Name	Member's First Name
SCAN ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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1. Is the prescription initially written or recommended by an endocrinologist?
2. Is the patient currently using insulin?
3. Does the patient have a poor compliance with the current oral hypoglycemic agents and/or insulin regimen (refills are not being filled monthly)?
4. Does the patient have a poor compliance with monitoring their blood glucose with a self-blood glucose monitoring system (not filling strips on a monthly basis)?
5. Does the patient have an HBA_{1C} greater than 9% (based on the most current lab)?
6. Does the patient have a history of a recurrent severe hypoglycemia requiring assistance in the last 6 months?
7. Does the patient have a diagnosis of gastroparesis?
8. Is the patient currently taking Reglan (metoclopramide)?
9. Are there any other comments, diagnoses, symptoms, and/or any other information you feel is important to this review?

Notice: Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.