

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR SYMLIN**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Symlin Completion Instructions, F-00080A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Symlin form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. State the member's most current HbA1c.
_____ %

15. Date Member's HbA1c Measured

16. Is the member using Symlin for weight loss? Yes No

17. Is the member currently receiving insulin injections? Yes No

18. Is the member currently receiving meal-time insulin injections? Yes No

19. Is the member 18 years of age or older? Yes No

20. Does the member currently have or have a history of gastroparesis? Yes No

21. Does the member currently have or have a history of hypoglycemia unawareness? Yes No

22. Has the member required emergency treatment for severe hypoglycemia in the past six months? Yes No

If yes, how many times?

Zero

One

Two

Three or greater

Continued



SECTION VI — FOR PHARMACY PROVIDERS USING STAT-PA

| | |
|------------------------------------|---|
| 23. National Drug Code (11 Digits) | 24. Days' Supply Requested (Up to 365 Days) |
|------------------------------------|---|

25. NPI

26. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

27. Place of Service

28. Assigned PA Number

| | | |
|----------------|---------------------|-----------------------------|
| 29. Grant Date | 30. Expiration Date | 31. Number of Days Approved |
|----------------|---------------------|-----------------------------|

SECTION V — AUTHORIZED SIGNATURE

| | |
|----------------------------|-----------------|
| 32. SIGNATURE — Prescriber | 33. Date Signed |
|----------------------------|-----------------|

SECTION VI — ADDITIONAL INFORMATION

34. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.
