DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00080 (10/11)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

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.

Reset Form