Neighborhood Health Plan of Rhode Island
Medical Necessity Request Form
Symlin® (Pramlintide acetate injection)

Date of Request: _____

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Symlin® (Pramlintide). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	**Member ID Number: (required)** ☐☐☐☐☐☐☐☐☐
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)
Prescriber Name: (required)	**Contact Person at Office:**
Office Phone number: (required) ( ) -	**Office Fax Number: (required) ( ) -**

ASSESSMENT OF BENEFIT NEED:

1. Please describe which indication pramlintide will be treating:
   - ☐ Adjuvant therapy in Type 1 Diabetes
   - ☐ Adjuvant therapy in Type 2 Diabetes
2. Prescriber is an Endocrinologist. ☐ YES ☐ NO
3. Please indicate the patient's most recent A1C level in the box at the right and provide the date of diabetes therapy initiation and the most recent AIC test below and: **A1C %:** ☐

   Therapy Start Date: _____/_____/____ **Test Date:** ____/____/____
4. If pramlintide is being requested for the treatment adjuvant treatment of Type 1 or Type 2 Diabetes, please indicate which medications the patient has failed *in the past 6 months*:

Glimepiride (Amaryl)	☐	**Glyburide-Metformin HCL (Glucovance)**	☐
Chlorpropamide (Diabinese)	☐	**Metformin HCL (Glucophage)**	☐
Glipizide (Glucotrol)	☐	**Metformin HCL ER (Glucophage XR)**	☐
Glipizide XL (Glucotrol XL)	☐	**Repaglinide (Prandin)**	☐
Glipizide-Metformin HCL (Metaglip)	☐	**Nateglinide (Starlix)**	☐
Glyburide (Diabeta / Glynase / Micronase)	☐	**Insulin**	☐

5. Please indicate the type(s) of Insulin the patient has failed *in the past 6 months*:
   _____
6. Please indicate your desired outcome with this therapy:
   _____
7. If this is a renewal; has the desired outcome been achieved? YES☐ NO☐
8. Please indicate the dosing schedule and the dose you desire for your patient

DOSE	☐15mcg (initial) ☐30mcg ☐60 mcg (initial) ☐60mcg ☐120mcg ☐Other:_____
SCHEDULE	☐ Three times daily (preferred) ☐ Four times daily ☐ As needed

BENEFIT TERMS UPON APPROVAL:

If approved, pramlintide will be authorized initially for six months, then yearly renewal if therapy is successful in meeting physician defined outcomes.

All information provided on this form is accurate as of this date.

Provider Signature:_____NPI_____ **Date:**_____

Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945