

**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:

<b>Member Name: (required)</b>	<b>Member ID Number: (required)</b> <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
<b>Member Date of Birth: (required)</b> / /	<b>Member Sex:</b> M    F    (Circle One)										
<b>Prescriber Name: (required)</b>	<b>Contact Person at Office:</b>										
<b>Office Phone number: (required)</b> (    ) -	<b>Office Fax Number: (required)</b> (    ) -										

**ASSESSMENT OF BENEFIT NEED:**

- Please describe which indication pramlintide will be treating:
  - Adjuvant therapy in Type 1 Diabetes
  - Adjuvant therapy in Type 2 Diabetes
- Prescriber is an Endocrinologist.  YES                       NO
- 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 A1C 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*:

- |  |   |                          |
|--|---|--------------------------|
| <input type="checkbox"/> Glimepiride (Amaryl)                      | <input type="checkbox"/> Glyburide-Metformin HCL (Glucovance) | <input type="checkbox"/> |
| <input type="checkbox"/> Chlorpropamide (Diabinese)                | <input type="checkbox"/> Metformin HCL (Glucophage)           | <input type="checkbox"/> |
| <input type="checkbox"/> Glipizide (Glucotrol)                     | <input type="checkbox"/> Metformin HCL ER (Glucophage XR)     | <input type="checkbox"/> |
| <input type="checkbox"/> Glipizide XL (Glucotrol XL)               | <input type="checkbox"/> Repaglinide (Prandin)                | <input type="checkbox"/> |
| <input type="checkbox"/> Glipizide-Metformin HCL (Metaglip)        | <input type="checkbox"/> Nateglinide (Starlix)                | <input type="checkbox"/> |
| <input type="checkbox"/> Glyburide (Diabeta / Glynase / Micronase) | <input type="checkbox"/> Insulin                              | <input type="checkbox"/> |

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 <input type="checkbox"/> 15mcg (initial) <input type="checkbox"/> 30mcg <input type="checkbox"/> 60 mcg (initial) <input type="checkbox"/> 60mcg <input type="checkbox"/> 120mcg <input type="checkbox"/> Other: _____
SCHEDULE <input type="checkbox"/> Three times daily (preferred) <input type="checkbox"/> Four times daily <input type="checkbox"/> 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:** \_\_\_\_\_                      **Date:** \_\_\_\_\_

**Completed forms should be faxed to:  
Customer Service Department  
NHPRI  
(401) 427-6754**