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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Symlin

Prior Authorization of Benefits (PAB) Form
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-474-3341

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Symlin	□ 0.6 mg/mL □ 1 mg/mL	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes	□ No	Is the patient greater than or equal to 18 years of age?
□ Yes	□ No	Does the patient have a diagnosis of diabetes mellitus in the last 730 days?
□ Yes	□ No	Does the patient have a diagnosis of gastroparesis or diabetes with neurological manifestations in the last 730 days?
□ Yes	□ No	Does the patient have a history of a metoclopramide agent in the last 30 days?
□ Yes	□ No	Does the patient have history of an insulin agent in the last 30 days?
□ Yes	□ No	Does the patient have a diagnosis of hypoglycemia in the last 180 days?
□ Yes	□ No	Does the patient have an ER visit for hypoglycemia in the last 180 days?
□ Yes	□ No	Does the patient have a history of an HbA1c test in the last 180 days?

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.
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