



# TEXAS MEDICAID Clinical Edit Prior Authorization pramlintide (SYMLIN)

## STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

## STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

Indicate Primary Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

1. Is the client greater than or equal to ( $\geq$ ) 18 years of age?

Yes (Go to #2)

No (Deny)

2. Does the client have a diagnosis of diabetes mellitus in the last 730 days?

Yes (Go to #3)

No (Deny)

3. Does the client have a diagnosis of gastroparesis or diabetes with neurological manifestations in the last 730 days?

Yes (Deny)

No (Go to #4)

4. Does the client have a history of a metoclopramide agent in the last 30 days?

Yes (Deny)

No (Go to #5)

5. Does the client have history of an insulin agent in the last 30 days?

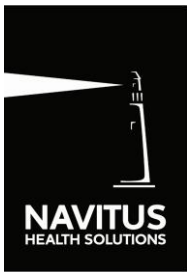
Yes (Go to #6)

No (Deny)

6. Does the client have a diagnosis of hypoglycemia in the last 180 days?

Yes (Go to #7)

No (Go to #8)



7. Does the client have an emergency room (ER) visit for hypoglycemia in the last 180 days?

Yes (Deny)

No (Go to #8)

8. Does the client have a history of an HbA1c test in the last 180 days?

Yes (Approve - 365 days)

No (Deny)

**STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
For questions, please call Navitus Customer Care at 1-877-908-6023.