# 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 (≥) 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.