Wellpoint

Symlin Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Nityr	☐ 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 and 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?

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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.	
The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.	

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not 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.