



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**Pramlintide (Symlin®) Initial
Prior Authorization Request Form**

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date Of Birth: ____/____/____

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____

Phone Number: (____) _____ Fax Number: (____) _____

NDC Requesting: _____

Physician's Printed Name: _____

Physician Medicaid ID #: _____ Physician NPI#: _____

Phone Number: (____) _____ Fax Number: (____) _____

PLEASE ANSWER ALL FOLLOWING QUESTIONS:

DIAGNOSIS: Type 1 diabetes? Yes ____ No ____

Type 2 diabetes? Yes ____ No ____

Current HbA1c (within 90 days) _____ Date: ____/____/____

- Does the patient have diagnosis of gastroparesis? Yes ____ No ____
- Has patient experienced recurrent severe hypoglycemia in past 6 months? Yes ____ No ____
- Does your medical record document inadequate postprandial glycemic control with current mealtime Insulin therapy? Yes ____ No ____
- Does your medical record document Symlin with concomitant use of mealtime insulin therapy.
Yes ____ No ____

Signature of Physician or Designee: _____ Date: ____/____/____

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**