NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT
AMYLINOMIMETIC AGENTS

Please go to NebraskaTotalCare.com for preferred drug list and criteria regarding prior authorizations

(NOTE: All Amylinomimetic agents approved subsequent to this bulletin shall be subject to these criteria.)
The first PA will be effective for 6 months; thereafter, a new PA must be requested every 12 months.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
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<tr>
<td>Symlin®</td>
<td>Pramlintide</td>
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**BRAND AND GENERIC NAME**

**PRESCRIBING PROVIDER:**
Name: ____________________________________  Name: _________________________________________
First Last  First Last
Phone #: ( ___ )- _____________________________  Medicaid #:______________________________________
Fax #: ( ___ )- ____________________________  Date of Birth: __ __/ __ __/ __ __ __ __

**PARTICIPATING PHARMACY:**
Name: ____________________________________  Request Date:  _______________________
Phone #: ( ____ )-  ___________________________  Fax #: (  )- ________________________

**Requested Drug Name:**
**Strength:**                                **Administration Schedule:**

**AMYLINOMIMETIC AGENT CRITERIA:** Client must be 18 years of age or older.

1. Is the patient currently using short-acting (Humalog®, Novolog®, Api®d®ra®, Humulin® R, Novolin® R, Humulin® 70/30, 50/50, NovoMix® 30) mealtime insulin injections? □ Yes □ No If no, denied.

2. Has the current mealtime insulin dose been reduced by 50% for initiation of amylinomimetic agent therapy? □ Yes □ No If no, denied

3. Is the patient receiving blood glucose testing supplies for Self-monitoring during amylinomimetic agent initiation? □ Yes □ No If no, denied

4. Does the patient show documented compliance with current therapy? (Compliance will be verified utilizing Medicaid claims data.) □ Yes □ No

(NOTE: Patient must be 18 years or older.)
5. Does the patient have a clinical diagnosis of gastroparesis? □ Yes □ No If yes, denied.

6. Is the patient HgbA1C>9? Please attach a copy of patient's most recent (within the previous 90 days) HgbA1C labs. □ Yes □ No If no, denied

Prescriber Signature: __________________________________________ Date: __________________________
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)

Please note: The Envolve Pharmacy Solutions may request chart documentation to verify the above information.
Submit requests to: Envolve Pharmacy Solutions, Inc. Fax: 1-877-386-4695 Tel: 1-844-330-7852

Revised Feb 2019