

This form is used for both preferred and non-preferred agents.
Form applies to IA Health Link and *hawk-i* plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for amylino mimetics (Symlin®). Payment will be considered under the following conditions: 1) Diagnosis of Type 1 or Type 2 diabetes mellitus, 2) Concurrent use of insulin therapy, 3) Documentation of blood glucose monitoring three or more times daily, 4) Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regimens. Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred: Symlin®

Strength: _____ Dosage Instructions: _____ Quantity: _____ Days Supply: _____

Diagnosis: _____

Concurrent mealtime insulin therapy to be used with Symlin®: _____

Insulin Product Name: _____

Trial start date: _____ Dose: _____

Patient is monitoring blood glucose levels three or more times/day: Yes No

Documentation of inadequate glycemic control with mealtime insulin therapy: _____

Insulin Product Name: _____

Trial start date: _____ Trial end date: _____ Reason for failure: _____

Most recent HbgA1C Level: _____ Date HbgA1C was obtained: _____

Other relevant information: _____

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature:
(Must match prescriber listed above.)

Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihhealthcaritasia.com/Provider to confirm your version of this form.