PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

SYMLIN
(pramlintide acetate)

SYMLINPEN
(pramlintide acetate)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Symlin/SymlinPen are indicated as an adjunctive treatment in patients with type 1 or type 2 diabetes who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has been receiving the requested drug for at least 3 months AND has demonstrated a reduction in A1c (hemoglobin A1c) since starting this therapy

OR

- The patient has a diagnosis of diabetes mellitus AND has failed to achieve desired glucose control despite receiving optimal insulin therapy, including mealtime insulin

REFERENCES

1. Symlin/SymlinPen [package insert]. San Diego, CA: Amylin Pharmaceuticals, Inc.; April 2016.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed July 2018.
3. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed July 2018.
4. Standards of Medical Care in Diabetes-2018: American Diabetes Association (ADA). *Diabetes Care* January 2018;41(Supplement1).
5. Garber AJ, et al. AACE/ACE Comprehensive Diabetes Management Algorithm 2018, Endocr Pract. 2018; 24 (No 1).
6. Handelsman Y, Bloomgarden ZT, Grunberger G, et al. American Association of Clinical Endocrinologists and American College of Endocrinology – Clinical Practice Guidelines for developing a diabetes mellitus comprehensive care plan. *Endocr Pract*. 2015;21(Suppl 1):1-87.