PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

SYMLINPEN
(pramlintide acetate)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Symlin is 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 a diagnosis of diabetes mellitus

AND

- The patient has NOT been receiving a stable maintenance dose of the requested drug for at least 3 months **AND**
    - The patient has failed to achieve desired glucose control despite receiving optimal insulin therapy, including mealtime insulin

OR

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

REFERENCES

1. SymlinPen [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; December 2019.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2022; Accessed June 22, 2022.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com. Accessed June 22, 2022.
4. American Diabetes Association. Standards of Medical Care in Diabetes-2022. Diabetes Care 2022;45(Supplement1):S1-S264.
5. Garber AJ, Handelsman Y, Grunberger G, et al. Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm-2020 Executive Summary. Endocr Pract. 2020;26(No 1):107-139.