

ALASKA MEDICAID

**Symlin® (Pramlintide Acetate)**

Vials: 5 mL, containing 0.6 mg/mL pramlintide (as acetate), for use with a syringe.<sup>1</sup>

**PREFERRED DRUG:**

NA

**NON-PREFERRED DRUG:**

NA

**INDICATION:**

“Symlin® is given at mealtimes and is indicated for:

- Type 1 diabetes, as an adjunct treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy.
- Type 2 diabetes, as an adjunct treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy, with or without a concurrent sulfonylurea agent and/or metformin.”<sup>1</sup>

**CRITERIA FOR APPROVAL:**

Symlin® coverage will be given if all of the following criteria are met:

1. Patient is 18 years of age or older; **AND**
2. Patient has been diagnosed with either type 1, or type 2 diabetes; **AND**
3. Patient has an HbA1c that is less than 9%; **AND**
4. Patient has received diabetic education that specifically covers the use of Symlin®, and is able to recognize the signs and symptoms of hypoglycemia.

**CRITERIA CAUSING DENIAL:**

Symlin® coverage will be denied if any one or more of the following conditions are met

1. Patient has severe hypoglycemia that has required assistance during the past 6 months.
2. Patient has a confirmed diagnosis of gastroparesis.
3. Patient requires the use of drugs that stimulate gastrointestinal motility.

**LENGTH OF AUTHORIZATION:**

1. Coverage may be approved for up to 6 months.

**REQUESTS FOR RENEWAL OF COVERAGE:**

Coverage may be extended beyond the initial 6 months if the patient's HbA1c has either:

1. Decreased by 10%; **OR**
2. Reached the documented goal of therapy.

**DISPENSING LIMIT:**

1. The dispensing limit is a 30 day supply of medication.

**REFERENCES / FOOTNOTES:**

<sup>1</sup> Symlin® package insert, available at: <<http://www.symlin.com/PDF/HCP/SYMLIN-pi-combined.pdf>> Accessed 05/16/07.