

Effective Date: February 1, 2007  
 Revised July 9, 2008

### CRITERIA FOR PRIOR AUTHORIZATION

Amylinomimetic agents

**PROVIDER GROUP:** Pharmacy

**MANUAL GUIDELINES:** The following drug(s) requires prior authorization:  
 Pramlintide (Symlin®)

**CRITERIA:** (must meet all of the following)

1. Patient must be at least 18 years old and have a diagnosis of Type 1 or Type 2 diabetes with HbA1c  $\leq$  9%.
2. Patient must **not** have a diagnosis of gastroparesis or have experienced recurrent severe hypoglycemia in the last 6 months.
3. Documented inadequate postprandial glycemic control with current mealtime insulin therapy.
4. Concomitant use of mealtime insulin therapy.

Recommendations: Patient should perform frequent pre- and post-meal glucose monitoring. An initial 50% reduction in pre-meal doses of short-acting insulin is recommended.

Renewals will be approved based on documented improvement of glycemic control (HbA1c lowering from pretreatment levels) and/or achievement of therapeutic goals (eg. improvement of postprandial glycemic control) and lack of severe hypoglycemic episodes.

**Prior Authorizations will be approved for 6 months.**

  
 Drug Utilization Review Committee Director

Date

9/10/08

  
 Pharmacy Program Manager,  
 Kansas Health Policy Authority

Date

9/10/08



**SYMLIN-CRITERIA CLARIFICATION**

If increase in HBA1C on renewal is increased 1% and/or rationale for fluctuation is provided, renewal may be granted.

Authorized by: LeAnn Bell, Pharmacist  Date: November 3, 2010  
Pharmacy Program Manager

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Prior Authorization Supervisor