Pharmacy Medical Necessity Guidelines:
Symlin (pramlintide)

Effective: April 14, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Symlin (pramlintide) is an amylin analog indicated for patients with type 1 or type 2 diabetes who use mealtime insulin and have failed to achieve desired glycemic control despite optimal insulin therapy. Symlin delays gastric emptying, blunts pancreatic secretion of glucagon, and enhances satiety.

COVERAGE GUIDELINES

The plan may authorize coverage of a Symlin (pramlintide) for Members when **ALL** of the following criteria are met:

1. Member has a diagnosis of type 1 or type 2 diabetes mellitus

AND

2. Member has had an inadequate response to meal-time insulin after at least 3 months of therapy

LIMITATIONS

None

CODES

None

REFERENCES

1. Symlin (pramlintide) [prescribing information]. Wilmington, DE: AzstraZeneca; December 2019.
2. American Diabetes Association. Standards of medical care in diabetes – 2024. *Diabetes Care*. 2024;47(Suppl. 1):S1-S321.

APPROVAL HISTORY

October 11, 2022, 2017: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsements date(s) and changes made:

1. July 11, 2023: Effective August 1, 2023, updated criteria to remove oral step through requirements for the treatment of type 2 diabetes.
2. April 9, 2024: Effective May 1, 2024, updated RxUM fax number.
3. April 8, 2025: No changes
4. April 14, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services