

SYMLIN® (pramlintide acetate) Injection

Coverage Criteria: Symlin is covered for:

- 1) Type 1 diabetics: Using both basal insulin and short-acting insulin **AND** requires three or more insulin injections daily **OR** using an insulin pump
- 2) Type 2 diabetics: Receiving max doses of metformin **AND** using both basal insulin and short-acting insulin **AND** requires three or more insulin injections daily, **OR** using an insulin pump, **AND**
- 3) Have an A1C level between 7% and 9%, **OR** have marked variability in glucose levels,
- 4) Test their blood glucose levels at home three or more time each day, **AND**
- 5) Receive medical nutrition therapy,
- 6) Receive care from a healthcare provider skilled in the use of insulin and supported by the service of a diabetes educator. Symlin is not covered in combination with antidiabetic medications that have not been approved for combined use. A detailed coverage policy is available upon request.

PLEASE SEND COMPLETED FORM TO COVENTRY – PHARMACEUTICAL SERVICES
FAX: 877-548-7648 PHONE: 1-866-847-8279

Requesting Physician:	Office Contact:
Office Phone Number:	Office Fax Number:
Call Center ID: WEBSITE	

MEMBER INFORMATION

Patient Name:	DOB:
Customer Number:	Client Number:
Member ID#:	Date of Request:

MEDICATION INFORMATION

1.	Is this a NEW START or a continuation of therapy? <input type="checkbox"/> New Start <input type="checkbox"/> Continuation
2.	Please indicate diagnosis: <input type="checkbox"/> Type 1 diabetes <input type="checkbox"/> Type 2 diabetes <input type="checkbox"/> Other:
3.	How is optimal insulin therapy achieved? <input type="checkbox"/> Basal insulin <input type="checkbox"/> Short-acting insulin <input type="checkbox"/> Insulin pump
4.	Is the patient compliant with their current insulin regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	For Type 2 DM, is the patient currently receiving maximal daily doses (2 grams) of metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If no, does the patient have an intolerance or contraindication to metformin? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Please specify:
6.	Will the patient be taking any of the following antidiabetic medications <i>in combination</i> with Symlin?
	<input type="checkbox"/> thiazolidinediones (Actos, Avandia, Avandamet) <input type="checkbox"/> meglitinides (Prandin)
	<input type="checkbox"/> alpha-glucosidase inhibitors (Precose, Glyset) <input type="checkbox"/> D-phenylalanine derivatives (Starlix)
7.	Please provide the most recent A1C level? % Date: / /
8.	Does the patient test their blood glucose levels at home three or more times per day? <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Does the patient have marked day-to-day variability in glucose levels? <input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Is the patient receiving individualized medical nutrition therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Is the patient's care supported by the services of a diabetic educator? <input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Does the patient experience hypoglycemia unawareness? <input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Does the patient have gastroparesis, or take any medications that alter GI motility? <input type="checkbox"/> Yes <input type="checkbox"/> No

COMPLETE FOR CONTINUATION THERAPY ONLY

14.	When did the patient start Symlin therapy? Date: / /
15.	Has the patient experienced improved glycemic control since adding Symlin injection? <input type="checkbox"/> Yes <input type="checkbox"/> No
16.	What is the patient's most recent A1C level? % Date: / /
17.	Are any of the following factors present?
	<input type="checkbox"/> Persistent clinically significant nausea or associated abdominal pain <input type="checkbox"/> Noncompliance with insulin dose adjustments
	<input type="checkbox"/> Noncompliance with self-monitoring of blood glucose concentrations <input type="checkbox"/> Noncompliance with scheduled clinic visits

Note: Initial approvals will be granted for 6-months and are subject to a quantity limit of 3-vials per fill. Subsequent approvals will be granted for 1 year based on therapeutic response and tolerance and adherence to Symlin therapy.

Requesting physician specialty:	
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Physician's Signature: