UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1315-2
Program	NonFormulary
Medication	Invokana (canagliflozin)
P&T Approval Date	5/2020, 5/2021
Effective Date	8/1/2021; Oxford only: 8/1/2021

1. Background:

Farxiga (dapagliflozin)*, Invokana (canagliflozin)*, Jardiance (empagliflozin) and Steglatro (ertugliflozin)* are sodium-glucose co-transporter 2 (SGLT2) inhibitors indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Farxiga*, Invokana* and Jardiance have additional indications. Farxiga* is indicated to reduce the risk of hospitalization for heart failure in adults with type 2 diabetes mellitus and established cardiovascular disease (CVD) or multiple cardiovascular (CV) risk factors and to reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure (NYHA class II-IV) with reduced ejection fraction. Invokana* is indicated to reduce the risk of major adverse cardiovascular events (cardiovascular death, nonfatal myocardial infarction and nonfatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease (CVD), and to reduce the risk of end-stage kidney disease (ESKD), doubling of serum creatinine, cardiovascular (CV) death, and hospitalization for heart failure in adults with type 2 diabetes mellitus and diabetic nephropathy with albuminuria > 300 mg/day. Jardiance is indicated to reduce the risk of cardiovascular death in adult patients with type 2 diabetes mellitus and established cardiovascular disease.

2. Coverage Criteria:

A. Initial Authorization

1. **Invokana** will be approved based on **all** the following criteria:

   a. Diagnosis of type 2 diabetes mellitus

   -AND-

   b. Diagnosis of diabetic nephropathy with albuminuria > 300 mg/day

   -AND-

   c. Provider attests that Jardiance isn't a suitable treatment option

   -AND-

d. Submission of medical records (laboratory and clinical documentation) confirming diagnosis of kidney disease

Authorization will be issued for 12 months.

B. Reauthorization

1. **Invokana** will be approved based on the following criterion:

   a. Documentation of a positive clinical response to Invokana therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Jardiance [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; January 2020.
2. Invokana [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; August 2020.
3. Farxiga [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP.; May 2020.
4. Steglatro [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; March 2020.
5. American Diabetes Association. Standard of Medical Care in Diabetes- 2021. Diabetes Care 2021;44 (Supplement 1)

Program	NonFormulary – Invokana
Change Control	
Date	Change
5/2020	New program.
5/2021	Annual review. Updated background section and references.