1. **Background:**

Januvia (sitagliptin) is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Janumet (sitagliptin/metformin) and Janumet XR (sitagliptin/metformin extended-release) are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus when treatment with both sitagliptin and metformin/metformin extended-release is appropriate.

Members, who have received at least a 90 day supply of Januvia, Janumet or Janumet XR in the past 120 days as documented in claims history, will be allowed continued coverage of their current therapy.

2. **Coverage Criteria:**

A. **Januvia** will be approved based on the following criterion:

1. History of a three month trial resulting in a therapeutic failure, contraindication (e.g. risk factors for heart failure), or intolerance to both of the following (list reason for therapeutic failure, contraindication, or intolerance):
   a. Tradjenta (linagliptin)
   -AND-
   b. **One** of the following:
      (1) Nesina (alogliptin)
      (2) Onglyza (saxagliptin)

   **Authorization will be issued for 12 months**

B. **Janumet and Janumet XR** will be approved based on the following criterion:

1. History of a three month trial resulting in a therapeutic failure, contraindication (e.g. risk factors for heart failure), or intolerance to all of the following (list reason for therapeutic failure, contraindication, or intolerance):
   a. Jentadueto (linagliptin/metformin immediate-release)/ Jentadueto XR
(linagliptin/metformin extended-release)

-AND-

b. **One** of the following:

(1) Kazano (alogliptin/metformin immediate-release)
(2) Kombiglyze XR (saxagliptin/metformin extended-release)

**Authorization will be issued for 12 months**

*a* State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

*b* For Connecticut business only a 30 day trial will be required.

### 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:**


© 2019 UnitedHealthcare Services Inc.
10. American Diabetes Association; Pharmacologic Approaches to Glycemic Treatment: Standards of Medical Care in Diabetes 2018, Diabetes Care 2018 Jan;41 (Supplement 1):S73-S85.
11. American Diabetes Association; Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes. Diabetes Care 2018 Jan; 41(Supplement 1): S86-S104.

<table>
<thead>
<tr>
<th>Program</th>
<th>Notification – Diabetes Medication- DPP4 Inhibitors</th>
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<tr>
<td><strong>Change Control</strong></td>
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<tr>
<td>10/2018</td>
<td>Annual review. Updated references. Added Jentadueto XR as a Step 1 option.</td>
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<tr>
<td>10/2019</td>
<td>Annual review. Added information on automated approval language.</td>
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