UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

<table>
<thead>
<tr>
<th>Program Number</th>
<th>2020 P 1198-6</th>
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<tbody>
<tr>
<td>Program</td>
<td>Prior Authorization/Notification – Custom Oxford SoNY and SoCT - Diabetes Medications - DPP4 Inhibitors</td>
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<tr>
<td>Medication</td>
<td>Januvia (sitagliptin)<em>, Janumet (sitagliptin/metformin immediate-release)</em>, Janumet XR (sitagliptin/metformin extended-release)*</td>
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<tr>
<td>P&amp;T Approval Date</td>
<td>10/2016, 10/2017, 10/2018, 10/2019, 4/2020, 5/2020</td>
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<tr>
<td>Effective Date</td>
<td>Oxford: 7/1/2020</td>
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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.

2. **Coverage Criteria:**

   **A. Januvia*** will be approved based on the following criterion:
   
   1. History of a three month trial\(^b\) 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\(^b\) 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.

*Typically excluded from coverage*

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:**

11. American Diabetes Association; Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes. Diabetes Care 2020 Jan; 41(Supplement 1): S86-S104.

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<thead>
<tr>
<th>Program</th>
<th>Notification – Diabetes Medication- DPP4 Inhibitors</th>
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<tbody>
<tr>
<td>Change Control</td>
<td></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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<tr>
<td>4/2020</td>
<td>Removed the automated approval language.</td>
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<tr>
<td>5/2020</td>
<td>Added Januvia, Janumet and Janumet are typically excluded from coverage.</td>
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