UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number 2021 P 2245-8
Program Prior Authorization/Medical Necessity – Custom Oxford SoNY and SoCT - Diabetes Medications - DPP4 Inhibitors
Medication Januvia (sitagliptin)*, Janumet (sitagliptin/metformin immediate-release)*, Janumet XR (sitagliptin/metformin extended-release)*
Effective Date Oxford: 10/1/2021

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. Submission of medical records documenting a 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 (Document date and duration of trial):
   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. Submission of medical records documenting a 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 (Document date and duration of trial):
   a. Jentadueto (linagliptin/metformin immediate-release)/ Jentadueto XR (linagliptin/metformin extended-release)
      -AND-
   b. **One** of the following:

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

Authorization will be issued for 12 months

* 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:


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<tr>
<th>Program</th>
<th>Prior Authorization/Medical Necessity – Diabetes Medication- DPP4 Inhibitors</th>
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<tbody>
<tr>
<td>Change Control</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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<tr>
<td>8/2020</td>
<td>Added requirement for submission of medical records.</td>
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<tr>
<td>7/2021</td>
<td>Annual review. Updated references. Program type changed from Prior Authorization/Notification (P 1198-7) to Prior Authorization/Medical Necessity (P 2245-8).</td>
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