UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

<table>
<thead>
<tr>
<th>Program Number</th>
<th>2019 P 1200-6</th>
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<tbody>
<tr>
<td>Program</td>
<td>Prior Authorization/Notification – Custom Oxford SoNY and SoCT - Diabetes Medications - SGLT2 Inhibitors</td>
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<tr>
<td>Medication</td>
<td>Farxiga (dapagliflozin)<em>, Glyxambi (empagliflozin/linagliptan), Invokana (canagliflozin), Jardiance (empagliflozin), Qtern (dapagliflozin/saxagliptin)</em>, Segluromet (ertugliflozin/metformin)<em>, Steglatro (ertugliflozin)</em>, Steglujan (ertugliflozin/sitagliptin)<em>, Xigduo XR (dapagliflozin/metformin extended-release)</em></td>
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<td>Effective Date</td>
<td>Oxford: 5/1/2019</td>
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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.

Invokamet (canagliflozin/metformin), Invokamet XR (canagliflozin/metformin extended-release), Synjardy (empagliflozin/metformin), Synjardy XR (empagliflozin/metformin extended-release), Segluromet (ertugliflozin/metformin) and Xigduo XR (dapagliflozin/metformin extended-release) are SGLT2 inhibitors and biguanide combination medications indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus who are not adequately controlled on a regimen containing metformin or a SGLT2 inhibitor or in patients already being treated with both a SGLT2 inhibitor and metformin.

Glyxambi (empagliflozin/linagliptan), Qtern (dapagliflozin/saxagliptin) and Steglujan (ertugliflozin/sitagliptin) are combination SGLT2 inhibitors and dipeptidyl peptidase-4 (DPP-4) inhibitors indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus when treatment with both a SGLT2 and a DPP4 inhibitor is appropriate.

If a member has a prescription for metformin, Glyxambi, Invokana or Jardiance in the claims history within the previous 12 months, the claim for Glyxambi, Invokana, or Jardiance will automatically process. Members currently on Glyxambi, Invokana or Jardiance as documented in claims history will be allowed continued coverage of their current therapy. Members new to therapy will be required to meet the coverage criteria below.
2. **Coverage Criteria**: 

**Authorization**

**A. Glyxambi, Invokana and Jardiance** will be approved based on one of the following criteria:

1. History of failure, contraindication or intolerance to metformin (generic Glucophage, Glucophage XR)

   -OR-

2. **Both** of the following:
   
   a. Currently on therapy with Glyxambi, Invokana or Jardiance and is requesting continuation of the same therapy.

   -AND-

   b. **One** of the following:

      (1) Has not received a manufacturer supplied sample at no cost as a means to establish as a current user of Glyxambi, Invokana or Jardiance.

      -OR-

      (2) **Both** of the following:

         i. Has received a manufacturer supplied sample at no cost as a means to establish as a current user of Glyxambi, Invokana or Jardiance

         -AND-

         ii. History of failure, contraindication, or intolerance to metformin (generic Glucophage, Glucophage XR)

**Authorization will be issued for 12 months.**

**B. Farxiga* and Steglatro*** will be approved based on the following criteria:

1. History of a three month trial resulting in therapeutic failure, contraindication or intolerance to **both** of the following:

   a. Metformin (generic Glucophage, Glucophage XR)
-AND-

b. **Both** of the following:
   1. Invokana
   2. Jardiance

**Authorization will be issued for 12 months.**

**C. Xigduo XR*, Segluromet* will be approved based on the following criterion:**

1. History of a three month trial resulting in therapeutic failure, contraindication or intolerance to **both** of the following:
   a. Invokamet/Invokamet XR
   b. Synjardy/Synjardy XR

**Authorization will be issued for 12 months.**

**D. Qtern* and Steglujan* will be approved based on the following criteria:**

1. History of a three month trial resulting in therapeutic failure, contraindication or intolerance to **both** of the following:
   a. Metformin (generic Glucophage, Glucophage XR)  
   -AND-
   b. Glyxambi

**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.

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.
* Farxiga, Qtern, Segluromet, Steglatro, Steglujan and Xigduo XR are typically excluded from coverage. Tried/failed criteria may be in place. Please refer to plan specifics to determine coverage status.

4. References:

12. American Diabetes Association; Pharmacologic Approaches to Glycemic Treatment: Executive Summary: Standards of Medical Care in Diabetes 20122018, Diabetes Care 2018 Jan2:41 (Supplement 1)35:S73-S85.4-S10.
<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
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<tbody>
<tr>
<td>10/2017</td>
<td>Added Synjardy/Synjardy XR as step 1 agent for Xigduo XR. Updated references.</td>
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<tr>
<td>4/2018</td>
<td>Added Qtern, Segluromet, Steglatro and Steglujan as step 2 agents. Updated references.</td>
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<tr>
<td>8/2018</td>
<td>Modified the step criteria for Glyxambi to only require metformin, a sulfonylurea or a thiazolidinedione.</td>
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<tr>
<td>12/2018</td>
<td>Removed the sulfonylurea and thiazolidinedione requirement. Updated references.</td>
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<tr>
<td>2/2019</td>
<td>Modified the Qtern and Steglujan step.</td>
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