Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 7/26/2018**
Policy Number: PA.CP.PST.18	**Effective Date: 01/2018** **Revision Date: 07/18/2018**
Policy Name: Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	**HC Approval Date:**

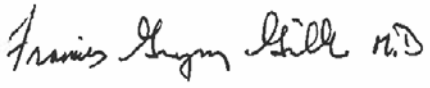
Type of Submission – Check all that apply:

- ☑ **New Policy**
- ☐ **Revised Policy***
- ☐ **Annual Review – No Revisions**
- ☐ **Attestation of HC PARP Policy** – *This option should only be used during Readiness Review for Community HealthChoices. The policy must be identical to the PARP approved policy for the HealthChoices Program, with the exception of revisions/clarifications adding the term "Community HealthChoices" to the policy.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

New Policy created.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:** 

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Plan: PA Health & Wellness	**Submission Date**:
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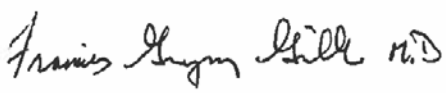
Please provide any changes or clarifying information for the policy below:

This policy is being retired and replaced by the following policy:

This policy is being replaced by the original policy CP.PMN.03 Dipeptidyl Peptidase-4 (DPP4) Inhibitors (no document to review).

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

Reference Number: PA.CP.PST.18
Effective Date: 03.01.18
Last Review Date: 07.18

Revision Log

Description
The following are dipeptidyl peptidase-4 (DPP-4) inhibitors requiring step therapy: alogliptin (Nesina®), alogliptin/metformin (Kazano®), alogliptin/pioglitazone (Oseni®), linagliptin (Tradjenta®), linagliptin/empagliflozin (Glyxambi®), linagliptin/metformin (Jentadueto®, Jentadueto® XR), saxagliptin (Onglyza®), saxagliptin/metformin (Kombiglyze® XR), sitagliptin (Januvia®), and sitagliptin/metformin (Janumet®, Janumet® XR).

FDA Approved Indication(s)
DPP-4 inhibitors are indicated as adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitation(s) of use:
- DPP-4 inhibitors should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.
- DPP-4 inhibitors have not been studied in patients with a history of pancreatitis.

Policy/Criteria
Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health & Wellness that DPP-4 inhibitors are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Step Therapy for DPP-4 Inhibitors (must meet all)**:**

1. Age ≥ 18 years;
2. Member meets one of the following (a or b):
   a. Previous use of ≥ 3 consecutive months of metformin, unless contraindicated or clinically significant adverse effects are experienced;
   b. HbA1c drawn within the past 3 months is ≥ 9%, and concurrent use of metformin unless contraindicated or clinically significant adverse effects are experienced;
3. If request is for a non-preferred DPP-4 inhibitor, member meets one of the following (a or b):
   a. For Glyxambi: Previous use of ≥ 3 consecutive months of a preferred DPP-4 inhibitor OR a preferred sodium-glucose co-transporter 2 (SGLT2) inhibitor, unless all are contraindicated or clinically significant adverse effects are experienced;
   b. For all other non-preferred DPP-4 inhibitors: Previous use of ≥ 3 consecutive months of a preferred DPP-4 inhibitor, unless contraindicated or clinically significant adverse effects are experienced;

4. Dose does not exceed the FDA approved maximum recommended dose.

Approval duration: 12 months

B. Other diagnoses/indications: Not applicable

II. Continued Therapy

A. Step Therapy for DPP-4 Inhibitors (must meet all)**:**

1. Currently receiving medication via PA Health &Wellness benefit or member has met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
2. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose.

Approval duration: 12 months

B. Other diagnoses/indications: Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AACE: American Association of Clinical Endocrinologists
ACE: American College of Endocrinology
ADA: American Diabetes Association
DPP-4: dipeptidyl peptidase-4
FDA: Food and Drug Administration
GLP-1: glucagon-like peptide-1
HbA1c: glycated hemoglobin
SGLT2: sodium-glucose co-transporter 2

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
metformin (Fortamet®, Glucophage®, Glucophage® XR, Glumetza®)	Regular-release (Glucophage): 500 mg PO BID or 850 mg PO QD; increase as needed in increments of 500 mg/week or 850 mg every 2 weeks Extended-release: • Fortamet, Glumetza: 1000 mg PO QD; increase as needed in increments of 500 mg/week • Glucophage XR: 500 mg PO QD; increase as needed in increments of 500 mg/week	Regular-release: 2550 mg/day Extended-release • Fortamet: 2500 mg/day • Glucophage XR, Glumetza: 2000 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: General Information

- A double-blind, placebo-controlled dose-response trial by Garber et al. found the maximal efficacy of metformin to occur at doses of 2000 mg. However, the difference in adjusted mean change in HbA1c between the 1500 and 2000 mg doses was 0.3%, suggesting that the improvement in glycemic control provided by the additional 500 mg may be insufficient when HbA1c is > 7%.
- Per the 2018 American Diabetes Association (ADA) and American Association of Clinical Endocrinologists and 2017 American College of Endocrinology (AACE/ACE) guidelines:
  - Metformin is recommended for all patients with type 2 diabetes. Monotherapy is recommended for most patients; however:
    - Starting with dual therapy (i.e., metformin plus another agent, such as a sulfonylurea, thiazolidinedione, DPP-4 inhibitor, SGLT2 inhibitor, glucagon-like peptide 1 [GLP-1] receptor agonist, or basal insulin) may be considered for patients with baseline HbA1c ≥ 9% per the ADA (≥ 7.5% per the AACE/ACE).
    - Starting with combination injectable therapy (i.e., with GLP-1 receptor agonist or insulin) may be considered for patients with baseline HbA1c ≥ 10% per the ADA (≥ 9% if symptoms are present per the AACE/ACE).
  - If the target HbA1c is not achieved after approximately 3 months of monotherapy, dual therapy should be initiated. If dual therapy is inadequate after 3 months, triple therapy should be initiated. Finally, if triple therapy fails to bring a patient to goal, combination injectable therapy should be initiated. Each non-insulin agent added to initial therapy can lower HbA1c by 0.9-1.1%.

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Glyxambi (linagliptin/empagliflozin)	5/10 mg PO once daily	5/25 mg/day
Janumet (sitagliptin/metformin)	Individualized dose PO twice daily	100/2000 mg/day
Janumet XR (sitagliptin/metformin)	Individualized dose PO once daily	100/2000 mg/day
Januvia (sitagliptin)	100 mg PO once daily	100 mg/day
Jentadueto (linagliptin/metformin)	Individualized dose PO twice daily	5/2000 mg/day
Jentadueto XR (linagliptin/metformin)	Individualized dose PO once daily	5/2000 mg/day
Kazano (alogliptin/metformin)	Individualized dose PO twice daily	25/2000 mg/day
Kombiglyze XR (saxagliptin/metformin)	Individualized dose PO once daily	5/2000 mg/day
Nesina (alogliptin)	25 mg PO once daily	25 mg/day
Onglyza (saxagliptin)	2.5 or 5 mg PO once daily	5 mg/day
Oseni (alogliptin/pioglitazone)	Individualized dose PO once daily	25/45 mg/day
Tradjenta (linagliptin)	5 mg PO once daily	5 mg/day

VI. Product Availability

Drug Name	Availability
Glyxambi (linagliptin /empagliflozin)	Tablets: 5/10 mg, 5/25 mg
Janumet (sitagliptin/metformin)	Tablets: 50/500 mg, 50/1000 mg
Janumet XR (sitagliptin/metformin)	Tablets: 100/1000 mg, 50/500 mg, 50/1000 mg
Januvia (sitagliptin)	Tablets: 25 mg, 50 mg, 100 mg
Jentadueto (linagliptin/metformin)	Tablets: 2.5/500 mg, 2.5/850 mg, 2.5/1000 mg
Jentadueto XR (linagliptin/metformin)	Tablets: 5/1000 mg, 2.5/1000 mg
Kazano (alogliptin/metformin)	Tablets: 12.5/500 mg, 12.5/1000 mg
Kombiglyze XR (saxagliptin/metformin)	Tablets: 5/500 mg, 5/1000 mg, 2.5/1000 mg
Nesina (alogliptin)	Tablets: 6.25 mg, 12.5 mg, 25 mg
Onglyza (saxagliptin)	Tablets: 2.5 mg, 5 mg
Oseni (alogliptin/pioglitazone)	Tablets: 12.5/15 mg, 12.5/30 mg, 12.5/45 mg, 25/15 mg, 25/30 mg, 25/45 mg
Tradjenta (linagliptin)	Tablets: 5 mg

VII. References

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
This policy is being replaced by the original policy CP.PMN.03 Dipeptidyl Peptidase-4 (DPP4) Inhibitors (no document to review).	01/19	