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:05/01/2019**
Policy Number: PA.CP.PST.19	**Effective Date: 003/01/2018** **Revision Date: 04/2019**
Policy Name: Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	**HC Approval Date:**

Type of Submission – Check all that apply:

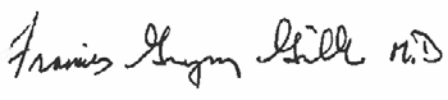
- ☐ **New Policy**
- ☐ **Revised Policy***
- ☐ **Annual Review – No Revisions**
- ☐ **Attestation of HC PARP Policy –** *This option should only be used during Readiness Review for Community HealthChoices. The policy must be identical to the PARP approved policy for the HealthChoices Program, with the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

This policy is being retired and replaced by the following:

PA.CP.PMN.14 Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors

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

Clinical Policy: Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors

Reference Number: PA.CP.PST.19
Effective Date: 03.01.18
Last Review Date: 07.18

Revision Log

Description
The following are sodium-glucose co-transporter 2 (SGLT2) inhibitors requiring step therapy: canagliflozin (Invokana®), canagliflozin/metformin (Invokamet®, Invokamet® XR), dapagliflozin (Farxiga®), dapagliflozin/metformin (Xigduo® XR), empagliflozin (Jardiance®), empagliflozin/linagliptin (Glyxambi®), and empagliflozin/metformin (Synjardy®, Synjardy® XR).

FDA Approved Indication(s)
SGLT2 inhibitors are indicated as adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Jardiance is also indicated to reduce the risk of cardiovascular death in adult patients with type 2 diabetes mellitus and established cardiovascular disease.

Limitation(s) of use: SGLT2 inhibitors should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.

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 SGLT2 inhibitors are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Step Therapy for SGLT2 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 SGLT2 inhibitor, member meets one of the following (a or b):
   a. For Glyxambi: Previous use of ≥ 3 consecutive months of a preferred SGLT2 inhibitor OR a preferred dipeptidyl peptidase-4 (DPP-4) inhibitor, unless all are contraindicated or clinically significant adverse effects are experienced;

b. For all other non-preferred SGLT2 inhibitors: Previous use of ≥ 3 consecutive months of a preferred SGLT2 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 SGLT2 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
ER: extended-release
FDA: Food and Drug Administration
GLP-1: glucagon-like peptide-1
HbA1c: glycated hemoglobin
IR: immediate-release
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	Regular-release: 2550 mg/day Extended-release • Fortamet: 2500 mg/day • Glucophage XR, Glumetza: 2000 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	• Glucophage XR: 500 mg PO QD; increase as needed in increments of 500 mg/week	

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 2017 American Association of Clinical Endocrinologists and 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
Farxiga (dapagliflozin)	5 mg PO once daily	10 mg/day
Glyxambi (empagliflozin/linagliptin)	10/5 mg PO once daily	25/5 mg/day
Invokamet (canagliflozin/metformin)	One 50/500 mg tablet PO twice daily	300/2000 mg/day
Invokamet XR (canagliflozin/metformin)	Two 50/500 mg tablets PO once daily	300/2000 mg/day
Invokana (canagliflozin)	100 mg PO once daily	300 mg/day
Jardiance (empagliflozin)	10 mg PO once daily	25 mg/day
Synjardy (empagliflozin/metformin)	Individualized dose PO twice daily	25/2000 mg/day
Synjardy XR (empagliflozin/metformin)	Individualized dose PO once daily	25/2000 mg/day

Drug Name	Dosing Regimen	Maximum Dose
Xigduo XR (dapagliflozin/metformin)	Individualized dose PO once daily	10/2000 mg/day

VI. Product Availability

Drug Name	Availability
Farxiga (dapagliflozin)	Tablets: 5 mg, 10 mg
Glyxambi (empagliflozin/linagliptin)	Tablets: 10/5 mg, 25/5 mg
Invokamet (canagliflozin/metformin)	Tablets: 50/500 mg, 50/1000 mg, 150/500 mg, 150/1000 mg
Invokamet XR (canagliflozin/metformin)	Tablets: 50/500 mg, 50/1000 mg, 150/500 mg, 150/1000 mg
Invokana (canagliflozin)	Tablets: 100 mg, 300 mg
Jardiance (empagliflozin)	Tablets: 10 mg, 25 mg
Synjardy (empagliflozin/metformin)	Tablets: 5/500 mg, 5/1000 mg, 12.5/500 mg, 12.5/1000 mg
Synjardy XR (empagliflozin/metformin)	Tablets: 5/1000 mg, 10/1000 mg, 12.5/1000 mg, 25/1000 mg
Xigduo XR (dapagliflozin/metformin)	Tablets: 2.5/1000 mg, 5/500 mg, 5/1000 mg, 10/500 mg, 10/1000 mg

VII. References

1. American Diabetes Association. Standards of medical care in diabetes—2018. Diabetes Care. 2018; 41(suppl 1): S1-S159.
2. Farxiga Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; October 2017. Available at: www.farxiga.com. Accessed November 29, 2017.
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11. Garber AJ, Duncan TG, Goodman AM, et al. Efficacy of metformin in type II diabetes: results of a double-blind, placebo-controlled, dose-response trial. Am J Med. 1997; 102: 491-497.
12. Garber AJ, Abrahamson MJ, Barzilay, JI, et al. Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the comprehensive type 2 diabetes management algorithm – 2017 executive summary. Endocr Pract. 2017; 23(2): 207-238.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
This policy is being retired and replaced by the following: PA.CP.PMN.14 Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	4/19	