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: 11/2020**
Policy Number: PHW.PDL.111	**Effective Date: 01/01/2020** **Revision Date: 11/2020**
Policy Name: Hypoglycemics, Incretin Mimetics/Enhancers	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***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:

Q1 2021: policy revised according to DHS revisions effective 01/05/2021

Name of Authorized Individual (Please type or print): **Auren Weinberg, MD**	**Name of Authorized Individual (Please type or print):** **Auren Weinberg, MD**

Clinical Policy: Hypoglycemics, Incretin Mimetics/Enhancers

Reference Number: PHW.PDL.111
Effective Date: 01/01/2020
Last Review Date: 11/2020

Revision Log

Policy/Criteria
Provider must submit documentation (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 and Wellness® that Incretin Mimetic/Enhancer Hypoglycemis are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Hypoglycemics, Incretin Mimetics/Enhancers

A. Prescriptions That Require Prior Authorization

All prescriptions for Hypoglycemics, Incretin Mimetics/Enhancers must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Hypoglycemic, Incretin Mimetic/Enhancer for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication, excluding use to treat obesity; **AND**

2. For a glucagon-like peptide-1 (GLP-1) receptor agonist or dipeptidyl peptidase-4 (DPP-4) inhibitor for the treatment of type 2 diabetes, has a documented history of **one** of the following:

   a. Failure to achieve glycemic control as evidenced by the beneficiary's HbA1c values using maximum tolerated doses of metformin,

   b. A contraindication or intolerance to metformin,

   c. Requires initial dual therapy with metformin based on HbA1c as defined by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology,

   d. For a GLP-1 receptor agonist or DPP-4 inhibitor with proven cardiovascular disease (CVD), heart failure (HF), or chronic kidney disease (CKD) benefit, has CVD (or two risk factors for CVD as identified by the American Diabetes

Association or the American Association of Clinical Endocrinologists and American College of Endocrinology), HF, or CKD;

AND

3. For a non-preferred Hypoglycemics, Incretin Mimetic/Enhancer, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Hypoglycemics, Incretin Mimetics/Enhancers with the same mechanism of action

AND

4. For an amylin analog, **all** of the following:

   a. For a diagnosis of type 2 diabetes mellitus, has a documented history of **one** of the following:

      i. Failure to achieve glycemic control as evidenced by the beneficiary's HbA1c values using maximum tolerated doses of metformin
      ii. A contraindication or intolerance to metformin,

   b. Failed to achieve adequate glycemic control as evidenced by the beneficiary's HbA1c values despite compliance with optimal insulin therapy,

   c. Will be prescribed the requested amylin analog in combination with insulin;

   AND

5. For therapeutic duplication, **one** of the following:

   a. Is being transitioned to or from another Hypoglycemics, Incretin Mimetic/Enhancer with the intent of discontinuing one of the medications
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

   AND

6. If a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRESCRIPTIONS FOR AN AMYLIN ANALOG: Requests for prior authorization of renewals of prescriptions for an amylin analog that were previously approved will take into account whether the beneficiary:

1. Has improved glycemic control as evidenced by a recent HbA1c value; **AND**

2. For therapeutic duplication, **one** of the following:

   a. Is being transitioned to or from another Hypoglycemics, Incretin Mimetic/Enhancer with the intent of discontinuing one of the medications
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

   AND

3. If a prescription for an amylin analog is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer. If the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the applicable guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. **Approval Duration: 12 months**

E. References

1. American Diabetes Association. Pharmacologic approaches to glycemic treatment. Sec. 9. In Standards of Medical Care in Diabetes – 2020. Diabetes Care 2020 Jan; 43 (Supplement 1): S98-S110. https://doi.org/10.2337/dc20-S009
2. American Diabetes Association. Cardiovascular disease and risk management. Sec. 10. In Standards of Medical Care in Diabetes – 2020. 020 Jan; 43 (Supplement 1): S98-S110. https://doi.org/10.2337/dc20-S009

3. Garber AJ, Handelsman Y, et al. Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the comprehensive type 2 diabetes management algorithm – 2020 executive summary. Endocrine Practice. 2020;26(1):107-139.
4. Symlin prescribing information. AstraZeneca Pharmaceuticals. LP Wilmington, DE. 2015

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020