Clinical Policy: Hypoglycemics, SGLT2 Inhibitors

Reference Number: PHW.PDL.535
Effective Date: 01/01/2020
Last Review Date: 11/2024

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 PA Health & Wellness® that SGLT2 Inhibitor Hypoglycemics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Hypoglycemics, SGLT2 Inhibitors

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, SGLT2 Inhibitors that meet any of the following conditions must be prior authorized:

1. A non-preferred Hypoglycemic, SGLT2 Inhibitor.

2. A Hypoglycemic, SGLT2 Inhibitor with a prescribed quantity that exceeds the quantity limit.

3. A Hypoglycemic, SGLT2 Inhibitor when there is a record of a recent paid claim for another Hypoglycemic, SGLT2 Inhibitor (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Hypoglycemics, SGLT2 Inhibitor, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

AND

1. For a non-preferred Hypoglycemics, SGLT2 Inhibitor, has a history of therapeutic failure of or a contraindication, or an intolerance of the preferred Hypoglycemics, SGLT2 Inhibitors approved or medically accepted for the beneficiary's diagnosis; **AND**

2. For therapeutic duplication, one of the following:

   a. Is being transitioned to or from another Hypoglycemics, SGLT2 Inhibitor 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 medical literature or national treatment guidelines;

AND

3. If a prescription for a Hypoglycemics, SGLT2 Inhibitor 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, SGLT2 Inhibitor. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the 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**

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
Q1 2023: policy revised according to DHS revisions effective 01/09/2023	10/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024