# Clinical Policy: Diabetes – Non-Insulin

Reference Number: OH.PHAR.PPA.50
Effective Date: 01.20 Revision Log
Last Review Date: 10.20
Line of Business: Medicaid

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Description**
Refer to *Appendix A* for drug coverage table.

**FDA approved indication(s)**
All non-insulin diabetes products are indicated for treatment of type 2 diabetes mellitus (T2DM).

Jardiance is also indicated for reduction of cardiovascular mortality due to major cardiovascular events (MACE) and the reduction of heart failure hospitalizations in T2DM patients with established cardiovascular disease.

Farxiga and Xigduo XR are also indicated for reduction of heart failure hospitalizations in adults with T2DM and established cardiovascular (CV) disease or multiple CV risk factors.

Invokana is also indicated for the reduction of cardiovascular mortality and MACE in T2DM patients with established cardiac disease; also to reduce the risk of end-stage kidney disease (ESKD), doubling of serum creatinine, and reduction of heart failure hospitalizations and CV death in adults with T2DM and diabetic nephropathy with albuminuria more than 300 mg/day.

Symlin is also indicated for adjunct treatment of type 1 diabetes mellitus in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy.

Victoza is also indicated for reduction of cardiovascular mortality and CV events (e.g., non-fatal myocardial infarction or non-fatal stroke) in type 2 diabetes mellitus patients who also have established CV disease and for the treatment of obesity as an adjunct to a reduced-calorie diet and increased physical activity.

**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 Buckeye Health Plan, an affiliate of Centene Corporation® that Non-Insulin products are **medically necessary** when the following criteria are met:

## I. Initial Approval Criteria

1. Prescribed indication is FDA-approved or supported by standard pharmacopeias;
2. Member must meet labeled age requirements for the medication;

**3.** If request is for a step therapy SGLT2 Inhibitor medication (Farxiga, Invokana, and Jardiance) member meets any of the following (a or b):
   a) Diagnosis of heart failure, chronic kidney disease or cardiovascular disease
   b) Multiple cardiovascular risk factors
   c) If (a) or (b) above are not met, member meets all of the following:

i. Failure of ≥ 60 days of at least one preferred metformin product (either single-ingredient or in sulfonylurea/metformin of TZD/metformin combination), unless member meets one of the following (i, ii, or iii);
   1. Allergy to medications not requiring prior approval;
   2. Contraindication to or drug interaction with medications not requiring prior approval;
   3. History of unacceptable/toxic side effects to medications not requiring prior approval;

ii. HbA1c drawn within the past 3 months is ≥ 8.5%;

**4.** If request is for a step therapy medication **NOT** Farxiga, Invokana, or Jardiance, member meets all of the following (i and ii):

i. Failure of ≥ 60 days of at least one preferred metformin product (either single-ingredient or in sulfonylurea/metformin of TZD/metformin combination), unless member meets one of the following (i, ii, or iii);
   1. Allergy to medications not requiring prior approval;
   2. Contraindication to or drug interaction with medications not requiring prior approval;
   3. History of unacceptable/toxic side effects to medications not requiring prior approval;

ii. HbA1c drawn within the past 3 months is ≥ 8.5%;

**5.** If request is for a non-preferred medication, member meets all of the following (a, b, and c):

i. Failure of ≥ 60 days of at least one preferred metformin product (either single-ingredient or in sulfonylurea/metformin of thiazolidinedione (TZD)/metformin combination), unless member meets one of the following (i, ii, or iii);
   i. Allergy to medications not requiring prior approval;
   ii. Contraindication to or drug interaction with medications not requiring prior approval;
   iii. History of unacceptable/toxic side effects to medications not requiring prior approval;

ii. Failure of ≥ 60 days of at least one preferred or step therapy product, unless member meets one of the following (i, ii, or iii);
   i. Allergy to medications not requiring prior approval;

ii. Contraindication to or drug interaction with medications not requiring prior approval;
iii. History of unacceptable/toxic side effects to medications not requiring prior approval;

c. HbA1c drawn within the past 3 months is ≥ 8.5%;

6. If request is for Qtern® or Steglujan®, failure of ≥ 60 days of at least one preferred Dipeptidyl Peptidase-4 (DPP-4) inhibitor and Sodium-Glucose Co-Transporter 2 (SGLT2) inhibitor;
7. If request is for Symlin®, failure of ≥ 60 days of at least one preferred insulin product;
8. If request is for Soliqua® or Xultophy®, documentation must address inability to use the individual components.

**Approval Duration: 12 months**

## II. Continued Therapy

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA-approved maximum recommended dose.

**Approval duration: 12 months**

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

**A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Drug Coverage Table*

**DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| METFORMIN (generic of Glucophage®)<br>METFORMIN ER (generic of Glucophage XR®) | | GLUCOPHAGE®, GLUCOPHAGE® XR (metformin)<br>METFORMIN ER (generic of Fortamet®)<br>METFORMIN SOLUTION (generic of Riomet®) |

**DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDE/SULFONYLUREA COMBO**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| GLIPIZIDE/METFORMIN (generic of Metaglip®)<br>GLYBURIDE/METFORMIN (generic of Glucovance®) | | METAGLIP® (glipizide/metformin)<br>GLUCOVANCE® (glyburide/metformin) |

**DIABETES – ORAL HYPOGLYCEMICS, TZD / BIGUANIDE COMBO**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| PIOGLITAZONE/ METFORMIN (generic of ActoPlus Met®) | ACTOPLUS MET XR® (pioglitazone/metformin) | |

**DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | JANUVIA® (sitagliptin)<br>TRADJENTA™ (linagliptin) | ALOGLIPTIN (generic of Nesina®)<br>ONGLYZA® (saxagliptin) |

**DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR COMBINATIONS**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | JANUMET™ (sitagliptin/ metformin)<br>JANUMET XR™ (sitagliptin/ metformin)<br>JENTADUETO™ (linagliptin/ metformin) | JENTADUETO® XR (linagliptin/ metformin)<br>ALOGLIPTIN/METFORMIN (generic of Kazano®)<br>KOMBIGLYZE XR® (saxagliptin/metformin) |

**DIABETES – ORAL HYPOGLYCEMICS, TZD / DPP-4 COMBINATION**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | | PIOGLITAZONE/ALOGLIPTIN (generic of Oseni®) |

**DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | FARXIGA® (dapagliflozin)*<br>INVOKANA® (canagliflozin)<br>JARDIANCE® (empagliflozin) | STEGLATRO™ (ertugliflozin) |

*Step Therapy Requirements are waived for members with a diagnosis of Heart Failure, Chronic Kidney Disease, Cardiovascular Disease or with multiple Cardiovascular Disease risk factors

**DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR COMBINATIONS**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|

| | | |
|---|---|---|
| | INVOKAMET® (canagliflozin/ metformin)<br>SYNJARDY® (empagliflozin/metformin) | INVOKAMET® XR (canagliflozin/ metformin)<br>SEGLUROMET™ (ertugliflozin/metformin)<br>SYNJARDY® XR (empagliflozin and metformin)<br>XIGDUO XR® (dapagliflozin/ metformin)<br>TRIJARDY® XR (empagliflozin/ linagliptin/metformin) |

**DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR AND DPP-4 COMBINATIONS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| No less than 90 days of at least one preferred DPP-4 and SGLT product | QTERN® (dapaglifozin-saxagliptin)<br>STEGLUJAN™ (ertugliflozin/sitagliptin)<br>GLYXAMBI® (empagliflozin/ linagliptin) |

**DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| ACARBOSE (generic of Precose®) | MIGLITOL (GENERIC OF GLYSET®) | |

**DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| NATEGLINIDE (generic of Starlix®)<br>REPAGLINIDE (generic of Prandin®) | | |

**DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDE/BIGUANIDE COMBO**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| REPAGLINIDE/ METFORMIN (generic of Prandimet®) | | |

**DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS SECOND GENERATION**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| GLIMEPIRIDE (generic of Amaryl®)<br>GLIPIZIDE (generic of Glucotrol®)<br>GLIPIZIDE ER (generic of Glucotrol XL®)<br>GLYBURIDE (generic of Diabeta®, Micronase®)<br>GLYBURIDE MICRONIZED (generic of Glynase PresTabs®) | | |

**DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| PIOGLITAZONE (generic of Actos®) | | AVANDIA® (rosiglitazone) |

**DIABETES – ORAL HYPOGLYCEMICS, TZD/SULFONYLUREAS COMBO**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | | GLIMEPIRIDE/PIOGLITAZONE (generic of Duetact®) |

**ENDOCRINE AGENTS: DIABETES – AMYLIN ANALOGS**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| No less than 90 days of at least one preferred insulin product | SYMLIN® (pramlintide) | |

**ENDOCRINE AGENTS: DIABETES –GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | VICTOZA® (liraglutide)<br>TRULICITY® (dulaglutide) | ADLYXIN™ (lixisenatide)<br>BYDUREON® (exenatide)<br>BYDUREON® BCISE (exenatide)<br>BYETTA™ (exenatide)<br>OZEMPIC® (semaglutide)<br>RYBELSUS® (SEMAGLUTIDE) |

**ENDOCRINE AGENTS: DIABETES – GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS & INSULIN COMBINATIONS**

| NO PA REQUIRED "PREFERRED" | STEP THERAPY REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|---|
| | | SOLIQUA™ 100/33 (insulin glargine/lixisenatide)<br>XULTOPHY® 100/3.6 (insulin degludec and liraglutide) |

*Appendix B: Abbreviation Key*
CV: cardiovascular
DPP-4: Dipeptidyl Peptidase-4
ESKD: end stage kidney disease
FDA: Food and Drug Administration
MACE: major cardiovascular events
SGLT2: Sodium-Glucose Co-Transporter 2
T2DM: type 2 diabetes mellitus

TZD: thiazolidinedione

*Appendix C: Therapeutic Alternatives*

- Dosing varies by drug product. See FDA approved dosing and administration.

*Appendix D: Contraindications/Boxed Warnings*

- Refer to Clinical Pharmacology or other appropriate clinical resource.

**V. Dosage and Administration**

A. Varies by drug product. See FDA approved dosing and administration.

**VI. Product Availability**

A. Varies by drug product. Please refer to Clinical Pharmacology or other appropriate clinical resource for product availability.

**VII. References**

Refer to package inserts.

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Policy created | 10/19 | |
| Added Rybelsus as a non-preferred Glucagon-Like Peptide-1 Receptor Agonist | 03/20 | |
| Added continued therapy criteria (section II) | 04/20 | |
| Added Trijardy XR (empagliflozin/linagliptin/metformin) to the list of non-preferred SGLT2 inhibitor and combinations | 07.20 | |
| Added Farxiga and Invokana as step therapy, preferred SGLT2 inhibitors; added step therapy requirements for SGLT2 inhibitors are waived for members with a diagnosis of heart failure, chronic kidney disease, cardiovascular disease, or with multiple Cardiovascular disease risk factors; added Invokamet as a step therapy, preferred SGLT2 Inhibitor combination product; added miglitol as step therapy, preferred alpha-glucosidase inhibitor; changed required trial of a preferred product (metformin, or a preferred or step therapy product) to 60 days from 90 days. | 10.20 | |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice

current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.