Pharmacy Medical Necessity Guidelines:
Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitors

Effective: April 1, 2021

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

The sodium-glucose cotransporter 2 inhibitors (SGLT2s) are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Dapagliflozin is also approved to reduce the risk of hospitalization for heart failure in adults with type 2 diabetes and established cardiovascular disease (CVD) or multiple cardiovascular (CV) risk factors. It is also indicated to reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure and reduced ejection fraction (NYHA class II-IV).

Canagliflozin is also approved to reduce the risk of major adverse CV events (CV death, nonfatal myocardial infarction and nonfatal stroke) in adults with type 2 diabetes and established CVD. Additionally, canagliflozin is approved to reduce the risk of end-stage kidney disease, doubling of serum creatinine, CV death, and hospitalization for heart failure in adults with type 2 diabetes and diabetic nephropathy and albuminuria > 300 mg/day. Canagliflozin is not recommended for use to improve glycemic control in adults with type 2 diabetes with an eGFR less than 30 mL/minute/1.73m^2, as canagliflozin is not likely to be effective in this setting.

Empagliflozin is also approved to reduce the risk of CV death in adult patients with type 2 diabetes mellitus and established CVD.

The table below summarizes the FDA-approved indications for the different SGLT-2 inhibitors.

Medication Name	Adjunct to diet and exercise in T2DM	Reduce risk of **major adverse CV events*** in adults with T2DM and established CVD	Reduce risk of ESKD, doubling of SCr, CV death, and hospitalization for HF in adults with T2DM and diabetic nephropathy	Reduce risk **of CV death** in adult patients with T2DM and established CVD	Reduce risk of hospitalization for HF in patients with T2DM and **established CVD** *OR* **multiple CV risk factors**	Reduce risk of CV death and hospitalization for HF in adults with HF with reduced EF (NYHA Class II-IV)
Canagliflozin	X	X	X			
Dapagliflozin	X				X	X
Empagliflozin	X			X		
Ertugliflozin	X					

*Major adverse CV events defined as CV death, nonfatal MI, nonfatal stroke
CVD = cardiovascular disease; EF = ejection fraction ESKD = end stage kidney disease; HF = heart failure; NYHA = New York Heart Association; SCr=serum creatinine; T2DM = type 2 diabetes mellitus

The American Diabetes Association guidelines for the treatment of type 2 diabetes recommend a glucagon-like peptide-1 (GLP-1) receptor antagonist or an SGLT-2 with proven CVD benefit in patients with established atherosclerotic cardiovascular disease (ASCVD). Additionally, an SGLT2 inhibitor with proven benefit in heart failure with reduced ejection fraction (HFrEF) is recommended in patients with heart failure. An SGLT2 inhibitor with evidence of reducing progression of chronic kidney disease is recommended in patients with diabetic kidney disease or albuminuria.

Tufts Health RITogether Preferred Drug List status for the SGLT-2 inhibitors is as follows:

Generic Name	Brand Name	PDL Status	Quantity Limitation
Canagliflozin	Invokana tablets	PA	100 mg: 2 tablets/day 300 mg: 1 tablet/day
Canagliflozin-Metformin	Invokamet tablets	PA	2 tablets/day
Canagliflozin-Metformin Extended Release	Invokamet XR tablets	PA	2 tablets/day
Dapagliflozin	Farxiga tablets	PA	1 tablet/day
Dapagliflozin-Metformin	Xigduo XR tablets	PA	10/1,000, 10/500 mg: 1 tablets/day; 2.5/1,000 mg, 5/1,000, 5/500 mg: 2 tablets/day
Empagliflozin	Jardiance	PA	1 tablet/day
Empagliflozin-Metformin	Synjardy	PA	2 tablet/day
Empagliflozin-Metformin Extended-Release	Synjardy XR	PA	10/1,000 mg: 1 tablet/day 25 mg/1,000 mg: 1 tablet/day 5 mg/1,000 mg: 2 tablets/day 12.5 mg/1,000 mg: 2 tablets/day
Ertugliflozin*	Steglatro	PA	N/A
Ertugliflozin-Metformin*	Segluromet	PA	N/A

*Steglatro (ertugliflozin) and Segluromet (ertugliflozin/metformin) are the preferred SGLT2s for RITogether members.

SGLT2 Inhibitors not included in the PDL or within the SGLT2 medical necessity guideline are considered non-covered.

COVERAGE GUIDELINES

The plan may authorize coverage of a sodium-glucose cotransporter 2 inhibitor for Members when the criteria are met and limitations do not apply:

Type 2 diabetes

1. The Member has a diagnosis of type 2 diabetes

AND

2. The Member has had an inadequate response, intolerance, or contraindication to metformin at the maximally tolerate dose

AND

3. The Member meets ONE of the following:
    a. The Member has had an inadequate response, intolerance, or contraindication to an ertugliflozin-containing product and at least one generic antihyperglycemic agent (e.g., sulfonylurea, pioglitazone, alogliptin)
    b. The Member has established cardiovascular disease (CVD) (e.g., ASCVD[†], heart failure), diabetic nephropathy, or two or more cardiovascular risk factors and the request is for a medication with that indication

[†]ASCVD defined as:

- Coronary heart disease (CHD) (myocardial infarction, angina, coronary artery disease)
- Cerebrovascular disease (e.g., transient ischemic attack, ischemic stroke)
- Peripheral artery disease
- Aortic atherosclerotic disease

*Cardiovascular risk factors include (but not limited to):

- Dyslipidemia
- Hypertension
- Current tobacco use

- Obesity/overweight
- Family history of premature ASCVD
- Chronic kidney disease
- Metabolic syndrome
- Presence of albuminuria

Heart Failure

1. The Member has a diagnosis of heart failure with reduced ejection fraction (HFrEF) NYHA class II, III, or IV

AND

2. The request is for a dapagliflozin-containing product

AND

3. The Member is currently being treated with either an angiotensin converting enzyme (ACE) inhibitor (e.g., lisinopril, benazepril), an angiotensin II receptor blocker (ARB) (e.g., candesartan, irbesartan, losartan, valsartan), or Entresto (sacubitril/valsartan), or the Member has contraindications to all three classes

AND

4. The Member is currently being treated with one of the following beta-blockers, or all three are contraindicated: bisoprolol, carvedilol (immediate- or extended-release), or metoprolol succinate

LIMITATIONS

1. The coverage of Invokana is limited to two tablets per day of the 100 mg strength, and one tablet per day of the 300 mg strength.
2. The coverage of Invokamet and Invokamet XR is limited to two tablets per day.
3. The coverage of Farxiga is limited to one tablet per day.
4. The coverage of Jardiance is limited to one tablet per day.
5. The coverage of Synjardy is limited to 2 tablets per day.
6. The coverage of Synjardy XR 10 mg/1,000 mg tablets and 25 mg/1,000 mg tablets is limited to 1 tablet per day.
7. The coverage of Synjardy XR 5 mg/1,000 mg tablets and 12.5 mg/1,000 mg tablets is limited to 2 tablets per day.
8. The coverage of Xigduo XR 2.5/1,000 mg tablets, 10/1,000 tablets, and 10/500 mg tablets is limited to 2 tablets per day.
9. The coverage of Xigduo XR 5/1,000 tablets and 5/500 mg tablets is limited to 1 tablet per day

CODES

None

REFERENCES

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APPROVAL HISTORY

December 12, 2013: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. June 12, 2014: No changes.
2. March 10, 2015: Xigduo XR added; approval duration limited to one year.
3. September 16, 2015: Approval duration approved for life of plan.
4. January 1, 2016: Administrative change to rebranded template.
5. January 12, 2016: No changes.
6. January 10, 2017: Added criteria and quantity limit for Invokamet XR.
7. May 9, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
8. November 14, 2017: No changes.
9. December 11, 2018: Effective 4/1/19, Steglatro and Segluromet are the preferred SGLT2 inhibitors. Steglatro, Segluromet, Jardiance, Synjardy, and Synjardy XR added to the Medical Necessity Guideline. Invokana, Invokamet, and Invokamet XR moved from first line SGLT2 inhibitors to second line. Added quantity limits for Xigduo XR, Jardiance, Synjardy, Synjardy XR. Removed step therapy language from the background section. Administrative changes made to template.
10. February 12, 2019: Administrative update, removed "Step Therapy" notation for Steglatro and Segluromet from the overview section of the MNG. Updated the quantity limits for Xigduo XR.
11. January 14, 2020: No changes.
12. January 12, 2021: Effective 4/1/2021, updated criteria to allow for approval of non-preferred SGLT-2 inhibitors based on cardiovascular or renal indications. Removed stability on the requested agent from the criteria.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are

made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.