

Market Applicability														
Market	DC	FL & FHK	FL MMA	FL LTC	GA	KS	KY	MD	NJ	NV	NY	TN	TX	WA
Applicable	X	X	NA	NA	X	NA	X	X	X	X	X	NA	NA	X

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## Sodium-Glucose Co-transporter-2 (SGLT2) Inhibitor Step Therapy

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Status	Quantity Limit
Jardiance (empagliflozin)	Preferred	May be subject to quantity limit
Synjardy (empagliflozin/metformin)		
Synjardy XR (empagliflozin/metformin extended-release)		
Farxiga (dapagliflozin)	Non-Preferred	
Invokamet (canagliflozin and metformin)		
Invokamet XR (canagliflozin and metformin extended-release)		
Invokana (canagliflozin)		
Segluromet (ertugliflozin/metformin)		
Steglatro (ertugliflozin)		
Xigduo XR (dapagliflozin/metformin extended release)		

### **APPROVAL CRITERIA**

Requests for Jardiance (empagliflozin), Synjardy (empagliflozin/metformin), or Synjardy XR (empagliflozin/metformin extended-release) may be approved when the following criteria are met:

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This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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Applicable	X	X	NA	NA	X	NA	X	X	X	X	X	NA	NA	X

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- I. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to metformin; **OR**
- II. Individual has a contraindication to metformin therapy [such as but not limited to, renal insufficiency (eGFR is less than 45 mL/minute/1.73 m<sup>2</sup>)].

Requests for Farxiga (dapagliflozin), Invokamet (canagliflozin/metformin), Invokamet XR (canagliflozin and metformin extended-release), Invokana (canagliflozin), Segluromet (ertugliflozin/metformin), Steglatro (ertugliflozin), or Xigduo XR (dapagliflozin/metformin extended-release) may be approved when the following criteria are met:

- I. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to metformin ; **OR**
- II. Individual has a contraindication to metformin therapy [such as but not limited to, renal insufficiency (eGFR is less than 45 mL/minute/1.73 m<sup>2</sup>)];

**AND**

- III. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to Jardiance (empagliflozin), Synjardy (empagliflozin/metformin) or Synjardy XR (empagliflozin/metformin extended-release).

A SGLT2 inhibitor **may not** be approved for any of the following:

- I. Individuals is requesting Invokamet (canagliflozin and metformin), Invokamet XR (canagliflozin and metformin extended-release), Invokana (canagliflozin), Synjardy (empagliflozin/metformin), or Synjardy XR (empagliflozin/metformin extended-release) or Jardiance (empagliflozin) with an eGFR less than 45 mL/min/1.73m<sup>2</sup>; **OR**
- II. Individual is requesting Farxiga (dapagliflozin), Segluromet (ertugliflozin/metformin), Steglatro (ertugliflozin) or Xigduo XR (dapagliflozin/metformin extended release) with an eGFR less than 60 mL/min/1.73 m<sup>2</sup>; **OR**
- III. Individual is requesting for the treatment of type 1 diabetes mellitus.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

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Applicable	X	X	NA	NA	X	NA	X	X	X	X	X	NA	NA	X

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**Key References:**

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2018. URL: <http://www.clinicalpharmacology.com>. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. <http://dailymed.nlm.nih.gov/dailymed/about.cfm>.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2018; Updated periodically.

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