### DPP-4 Inhibitor and Combo Products

Alogliptin

Alogliptin/metformin

Nesina (alogliptin)

Kazano (alogliptin/metformin)

Effective 01/01/2021

<table>
<thead>
<tr>
<th>Plan</th>
<th>Benefit</th>
<th>Program Type</th>
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<tr>
<td>☒ MassHealth</td>
<td>☒ Pharmacy Benefit</td>
<td>☑ Prior Authorization</td>
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<tr>
<td>☐ Commercial/Exchange</td>
<td>☐ Medical Benefit (NLX)</td>
<td>☐ Quantity Limit</td>
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<tr>
<td>☐ Commercial/Exchange</td>
<td>☐ Medical Benefit (NLX)</td>
<td>☐ Step Therapy</td>
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#### Specialty Limitations

N/A

#### Specialty Medications

<table>
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<tr>
<th>Plan</th>
<th>Specialty Medications</th>
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<tr>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
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#### Contact Information

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<thead>
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<tbody>
<tr>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
</tr>
<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
</tr>
<tr>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
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#### Non-Specialty Medications

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<th>Plan</th>
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<td>All Plans</td>
<td>Phone: 844-345-2803</td>
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#### Medical Specialty Medications (NLX)

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<td>All Plans</td>
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#### Exceptions

N/A

**Overview**

<table>
<thead>
<tr>
<th>No PA</th>
<th>PA required</th>
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<tbody>
<tr>
<td>Januvia® (sitagliptin)</td>
<td>Alogliptin</td>
</tr>
<tr>
<td>Onglyza® (saxagliptin)</td>
<td>Alogliptin/metformin</td>
</tr>
<tr>
<td>Tradjenta® (linagliptin)</td>
<td>Nesina® (alogliptin)†</td>
</tr>
<tr>
<td>Janumet® (sitagliptin/metformin)</td>
<td>Kazano® (alogliptin/metformin) †</td>
</tr>
<tr>
<td>Janumet XR® (sitagliptin/metformin extended-release)</td>
<td></td>
</tr>
<tr>
<td>Jentadueto® (linagliptin/metformin)</td>
<td></td>
</tr>
<tr>
<td>Kombiglyze® XR (saxagliptin/metformin extended-release)</td>
<td></td>
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</table>

†Authorized generic available. Both brand and authorized generic require PA.

**Coverage Guidelines**

Authorizations requests will be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

**OR**

Authorization may be granted for members when all the following criteria are met, and documentation is provided:
Alogliptin and Nesina® (alogliptin)
1. The member has a diagnosis of type 2 Diabetes Mellitus
2. The member meets ONE of the following:
   a. Prescriber documented inadequate response (defined as at least 90 days of therapy within a 120-day time period) to metformin used in combination with ONE of the following:
      i. Januvia® (sitagliptin)
      ii. Onglyza® (saxagliptin)
      iii. Tradjenta® (linagliptin)
   b. BOTH of the following:
      i. Adverse reaction or contraindication to metformin
      ii. Prescriber documented inadequate response (defined as at least 90 days of therapy within a 120-day time period) to ONE of the following:
         A. Januvia® (sitagliptin)
         B. Onglyza® (saxagliptin)
         C. Tradjenta® (linagliptin)
   c. BOTH of the following:
      i. Prescriber documented inadequate response (defined as at least 90 days of therapy within a 120-day time period), adverse reaction or contraindication to metformin.
      ii. Adverse reaction or contraindication to ONE of the following:
         A. Januvia® (sitagliptin)
         B. Onglyza® (saxagliptin)
         C. Tradjenta® (linagliptin)
3. If requested quantity exceeds 1 tablet/day, clinical rationale for exceeding FDA-approved dosing schedule

Alogliptin/metformin and Kazano® (alogliptin/metformin)
1. The member has a diagnosis of type 2 Diabetes Mellitus
2. The member meets ONE of the following:
   a. Prescriber documented inadequate response (defined as at least 90 days of therapy within a 120-day time period) to metformin used in combination with at least one of the non-metformin agents in the requested combination
   b. BOTH of the following:
      i. Adverse reaction or contraindication to metformin
      ii. Prescriber documented inadequate response (defined as at least 90 days of therapy within a 120-day time period) to at least one of the non-metformin agents in the requested combination
   c. BOTH of the following:
      i. Prescriber documented inadequate response (defined as at least 90 days of therapy within a 120-day time period), adverse reaction or contraindication to metformin.
      ii. Adverse reaction to at least one of the non-metformin agents in the requested combination
3. If the request is for BRAND NAME Kazano®, the member must meet the above criteria and provide medical records documenting an inadequate response or adverse reaction to the therapeutically equivalent generic formulation

Limitations
1. Initial approval and reauthorizations will be granted for 12 months.
2. The following quantity limits apply:
Alogliptin  
30 tablets per 30 days

Nesina  
30 tablets per 30 days

References

Review History
03/05/07 – Reviewed
04/23/07 – Reviewed
04/28/08 – Reviewed
07/16/08 – Tier 2 status
08/21/08 – Metformin-containing products
02/01/09 – Prandimet
04/27/09 – Reviewed
04/26/10 – Reviewed
12/15/10 – Disclaimer
01/03/11 – Kombiglyze XR
04/25/11 – Reviewed
06/06/11 – Tradjenta
03/19/12 – Jentadueto
04/23/12 – Updated
04/22/13 – Reviewed
04/28/14 – Updated
04/27/15 – Reviewed
04/25/16 – Reviewed
04/24/17 – Updated
04/17/19 – Reviewed
10/04/2020 – Updated; retired ST DDP-4 criteria replaced with PA criteria; references updated; Match Masshealth partial unified formulary requirements for implementation on 1/1/21

Disclaimer
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