Sodium Glucose CoTransporter 2 (SGLT2) Inhibitors
Steglatro (ertugliflozin)
Segluromet (ertugliflozin/linagliptin)
Glyxambi (empagliflozin/linagliptin)
Effective January 1, 2021

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Sodium-glucose cotransporter 2 (SGLT2) reduces reabsorption of filtered glucose from the tubular lumen and lowers the renal threshold for glucose (RT_G). SGLT2 is the main site of filtered glucose reabsorption; reduction of filtered glucose reabsorption and lowering of RT_G result in increased urinary excretion of glucose, thereby reducing plasma glucose concentrations.

No PA	PA required
Farxiga® (dapagliflozin)	Steglatro® (ertugliflozin)
Invokana® (canagliflozin)	Segluromet® (ertugliflozin/metformin
Invokamet® (canagliflozin/metformin)	Glyxambi® (empagliflozin/linagliptin)
Jardiance® (empagliflozin)	
Synjardy® (empagliflozin/metformin)	
Synjardy XR® (empagliflozin/metformin extended-release)	
Xigduo XR® (dapagliflozin/metformin extended-release)	

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:

Glyxambi® (empagliflozin/linagliptin) and Segluromet® (ertugliflozin/ metformin)
1. The member has a diagnosis of type 2 Diabetes Mellitus
2. **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

Steglatro® (ertugliflozin)
1. The member has a diagnosis of type 2 Diabetes Mellitus
2. **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. Farxiga® (dapagliflozin)
        ii. Invokana® (canagliflozin)
        iii. Jardiance® (empagliflozin)
    b. **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. Prescriber documented inadequate response (defined as at least 90 days of therapy within a 120-day time period) to **ONE** of the following:
            1) Farxiga® (dapagliflozin)
            2) Invokana® (canagliflozin)
            3) Jardiance® (empagliflozin)
    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. Contraindication to **ALL** of the following:
            1) Farxiga® (dapagliflozin)
            2) Invokana® (canagliflozin)
            3) Jardiance® (empagliflozin)
3. If requested quantity exceeds 1 tablet/day, clinical rationale for exceeding FDA-approved dosing schedule

Continuation criteria:

Reauthorization requires physician attestation of continuation of therapy and positive response to therapy.

Limitations

1. Initial approval and reauthorizations will be granted for 12 months.
2. The following quantity limits apply:

Farxiga® (dapagliflozin)	30 tablets per 30 days
Invokana® (canagliflozin)	30 tablets per 30 days
Invokamet® (canagliflozin/metformin)	60 tablets per 30 days
Jardiance® (empagliflozin)	30 tablets per 30 days
Synjardy® (empagliflozin/metformin)	60 tablets per 30 days
Steglatro® (ertugliflozin)	30 tablets per 30 days
Segluromet® (ertugliflozin/metformin	60 tablets per 30 days
Glyxambi® (empagliflozin/linagliptin)	30 tablets per 30 days

References

Review History

10/05/2020 – Implemented to match Masshealth partial unified formulary requirements for implementation on 1/1/21

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.