DPP-4 Inhibitor and Combo Products
Alogliptin
Alogliptin/metformin
Nesina (alogliptin)
Kazano (alogliptin/metformin)
Oseni (alogliptin/pioglitazone)
Effective 01/01/2022

<table>
<thead>
<tr>
<th>Plan</th>
<th>☐ MassHealth</th>
<th>☒ MH UPPL</th>
<th>☐ Commercial/Exchange</th>
<th>Program Type</th>
<th>☒ Prior Authorization</th>
<th>☐ Quantity Limit</th>
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<tr>
<td>Benefit</td>
<td>☒ Pharmacy Benefit</td>
<td>☐ Medical Benefit (NLX)</td>
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<th>Specialty Limitations</th>
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<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
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<tr>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
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<tr>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
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<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
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<tr>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
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| Medical Specialty Medications (NLX) | |
| All Plans | Phone: 844-345-2803 | Fax: 844-851-0882 |

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<tr>
<th>Exceptions</th>
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Overview

<table>
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<tr>
<th>No PA</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>
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<tr>
<td>Janumet XR® (sitagliptin/metformin extended-release)</td>
<td>Oseni® (alogliptin/pioglitazone) †§</td>
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<tr>
<td>Jentadueto® (linagliptin/metformin)</td>
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</tr>
<tr>
<td>Kombiglyze® XR (saxagliptin/metformin extended-release)</td>
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† Authorized generic available. Both brand and authorized generic require PA.
§ Brand Preferred over generic equivalents. In general, a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

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.
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. **ONE** of the following:
   a. Pharmacy claims or physician attestation of 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. Pharmacy claims or physician attestation of 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. Pharmacy claims or physician attestation of 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 **ONE** of the following:
         a) Januvia® (sitagliptin)
         b) Onglyza® (saxagliptin)
         c) Tradjenta® (linagliptin)
   d. **BOTH** of the following:
      i. Pharmacy claims or physician attestation of 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:
         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

† Authorized generic available. Both brand and authorized generic require PA.
§ Brand Preferred over generic equivalents. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

**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

Oseni® (alogliptin/pioglitazone)†§
1. The member has a diagnosis of type 2 Diabetes Mellitus
2. **ONE** of the following:
   a. Pharmacy claims or physician attestation of 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. Pharmacy claims or physician attestation of 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. Pharmacy claims or physician attestation of 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

† Authorized generic available. Both brand and authorized generic require PA.
§ Brand Preferred over generic equivalents. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

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

<table>
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<tr>
<th>Drug</th>
<th>Limit</th>
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<tr>
<td>Alogliptin</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Nesina</td>
<td>30 tablets per 30 days</td>
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**Appendix**

**Appendix A: Brand Preferred over Generic**

In addition to any prior authorization requirements that may be listed above, generic medications listed below have Brand name products that are Brand Name Preferred Over Generic

- alogliptin
- alogliptin/metformin
- alogliptin/pioglitazone
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
04/17/19 – Reviewed
10/04/2020 – Updated; retired ST DDP-4 criteria replaced with P
04/23/12 – Updated
04/22/13 – Reviewed
04/28/14 – Updated
04/27/15 – Reviewed
04/25/16 – Reviewed
04/24/17 – Updated
A criteria; references updated; Match Masshealth partial unified formulary requirements for implementation on 1/1/21
11/17/2021 – Reviewed and Updated for Nov P&T; Nesina® is now brand preferred, criteria updates to Nesina and alogliptan. Effective 1/1/2022

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