# Sodium-glucose Co-transporter 2 (SGLT-2) Inhibitors

**Effective April 17, 2019**

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>All Plans</th>
<th>Phone: 866-814-5506</th>
<th>Fax: 866-249-6155</th>
</tr>
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## Non-Specialty Medications

<table>
<thead>
<tr>
<th>Plan</th>
<th>MassHealth</th>
<th>Phone: 877-433-7643</th>
<th>Fax: 866-255-7569</th>
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<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td>Fax: 888-836-0730</td>
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<tr>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
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## Medical Specialty Medications (NLX)

<table>
<thead>
<tr>
<th>Plan</th>
<th>All Plans</th>
<th>Phone: 844-345-2803</th>
<th>Fax: 844-851-0882</th>
</tr>
</thead>
</table>

## Overview

Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

### Initial Step-Therapy Requirements:

**First-Line:** Medications listed on first-line are covered without prior-authorization.

**Second-Line:** Second-line medications will pay if the member has filled a first-line medication or a second-line medication within the past 180 days.

**Third-Line:** Third-line medications will pay if the member has filled a second-line medication as described below or a third-line medication within the past 180 days.

## Coverage Guidelines

<table>
<thead>
<tr>
<th><strong>FIRST-LINE</strong></th>
<th><strong>SECOND-LINE</strong></th>
<th><strong>THIRD-LINE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>metformin or a metformin-containing product</td>
<td>Invokana (canagliflozin)</td>
<td>Invokamet (canagliflozin/metformin)</td>
</tr>
<tr>
<td></td>
<td>Farxiga (dapagliflozin)</td>
<td>Xigduo XR (dapagliflozin/metformin ER)</td>
</tr>
<tr>
<td></td>
<td>Jardiance (empagliflozin)</td>
<td>Glyxambi (empagliflozin/linagliptin)</td>
</tr>
<tr>
<td></td>
<td>Tradjenta (linagliptin)</td>
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</tr>
</tbody>
</table>

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member meets the following criteria:
Invokana, Farxiga, Jardiance & Tradjenta

1. Patient must have a diagnosis of Type 2 diabetes AND

2. Patient has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)

   OR

2. Patient has had a documented inadequate response, side effect, allergy, or contraindication* to metformin or a metformin-containing product

Invokamet tablets

1. Patient must have a diagnosis of Type 2 diabetes AND

2. Patient has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)

   OR

2. Patient has had a documented inadequate response, side effect, allergy, or contraindication* to metformin or a metformin-containing product AND

3. Patient has had a documented inadequate response, side effect, allergy to Invokana (canagliflozin)

Xigduo XR tablets

1. Patient must have a diagnosis of Type 2 diabetes AND

2. Patient has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)

   OR

2. Patient has had a documented inadequate response, side effect, allergy, or contraindication* to metformin or a metformin-containing product AND

3. Patient has had a documented inadequate response, side effect, allergy to Farxiga (dapagliflozin)

Glyxambi tablets

1. Patient must have a Type 2 diabetes AND

2. Patient has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)

   OR

2. Patient has had a documented inadequate response, side effect, allergy, or contraindication* to metformin or a metformin-containing product AND

3. Patient has had a documented inadequate response, side effect, allergy to Jardiance (empagliflozin) or Tradjenta (linagliptin)

*Contraindication to metformin therapy would include but is not limited to renal insufficiency, liver disease, heart failure, or history of lactic acidosis etc.

Limitations

1. Approvals will be granted for 36 months.

References


Review History
04/28/14 – Reviewed
01/12/15 – Added Farxiga & Jardiance
04/27/15 – Updated
04/25/16 – Reviewed
04/24/17 – Reviewed
04/17/19 – Retired for CommExch

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