Sodium Glucose CoTransporter 2 (SGLT2) Inhibitors
Steglatro (ertugliflozin)
Segluromet (ertugliflozin/linagliptin)
Glyxambi (empagliflozin/linagliptin)
Duetact (glimepiride/pioglitazone)
Qtern (dapagliflozin/saxagliptin)
Repaglinide/metformin
Steglujan (ertugliflozin/sitagliptin)
Trijardy XR (empagliflozin/linagliptin/metformin extended release)
Effective 11/01/2022

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)	Duetact® (glimepiride/pioglitazone) *§
Synjardy® (empagliflozin/metformin)	Qtern® (dapagliflozin/saxagliptin)
Synjardy XR® (empagliflozin/metformin extended-release)	repaglinide/metformin

Xigduo XR® (dapagliflozin/metformin extended-release)	Steglujan® (ertugliflozin/sitagliptin)
	Trijardy XR® (empagliflozin/linagliptin/ metformin extended-release)

This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.
*A-rated generic available. Both brand and A-rated generic require PA.
†Authorized generic available. Both brand and authorized generic require PA.
PD Preferred Drug. In general, a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class. Please note, for Trulicity® (dulaglutide) and GLP-1 receptor agonists, a trial with a preferred agent is not required prior to approval of a non-preferred agent.
§ 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 the plan 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:

Duetact® (glimepiride/pioglitazone)*§
Glyxambi® (empagliflozin/linagliptin)
Segluromet® (ertugliflozin/ metformin)
Steglujan® (ertugliflozin/sitagliptin)
Repaglinide/metformin
Trijardy XR® (empagliflozin/linagliptin/ metformin extended-release)

1. Member has a diagnosis of Type 2 Diabetes Mellitus
2. **ONE** of the following:
    a. Paid 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. Paid 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. Paid 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
3. If the request is for Trijardy XR, clinical rationale for use of the combination product instead of the commercially available separate agents

*A-rated generic available. Both brand and A-rated 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.

Steglatro® (ertugliflozin)
Prescriber provides documentation of the following:
1. Member has a diagnosis of Type 2 Diabetes Mellitus
2. **ONE** of the following
    a. Paid 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. Farxiga® (dapagliflozin)
        ii. Invokana® (canagliflozin)
        iii. Jardiance® (empagliflozin)
    b. **BOTH** of the following:
        i. Paid claims or physician attestation of 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. Paid 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:
            1. Farxiga® (dapagliflozin)
            2. Invokana® (canagliflozin)
            3. Jardiance® (empagliflozin)
    d. **BOTH** of the following:
        i. Paid 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:
            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 of Therapy
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
Duetact® (glimepiride/pioglitazone)	30 tablets per 30 days
Qtern® (dapagliflozin/saxagliptin)	30 tablets per 30 days
Steglujan® (ertugliflozin/sitagliptin)	30 tablets per 30 days
Trijardy XR® (empagliflozin/linagliptin/ metformin extended-release)	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
11/17/2021 – Reviewed and Updated for Nov P&T; Qtern® (dapagliflozin/saxagliptin), repaglinide/metformin, Steglujan® (ertugliflozin/sitagliptin), and Trijardy XR® (empagliflozin/linagliptin/ metformin extended-release) added to UPPL criteria. , Duetact® is brand preferred as noted in the reference table. Effective 1/1/2022
11/16/2022 – Reviewed and updated for Nov P&T. Matched MH. Added criteria C for Steglatro: requiring an inadequate response, adverse reaction or contraindication to metformin AND adverse reaction to one of the agents (Farxiga, Invokana, Jardiance). Clarified Trijardy XR QL to 30 tablets per 30 days. Effective 11/01/2022

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