**Endocrine Agents: Diabetes – Insulin**

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| Criteria 1 | NP Agents- Admelog, Basaglar, Fiasp, Humalog U-200, Humulin N U-100, Humulin R U-100, Insulin Degludec (Tresiba is P, ST, BvG), Insulin Glargine (Lantus is P, BvG), Lyumjev, Novolin 70-30, Novolin N U-100, Novolin R U-100, Semglee, Rezvoglar, Basaglar Tempo Pen, Humalog U-100 Tempo Pen, Lyumjev Tempo Pen |
| Criteria 2 | NP Agents- Inhaled Insulin-  Afrezza |
| Criteria 3 | Tresiba (P, ST, BvG) |

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| **Criteria Title** | Endocrine Agents: Diabetes – Insulin | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ADMELOG | 027413 | GCNSeqNo |
| ADMELOG | 034731 | GCNSeqNo |
| BASAGLAR | 062867 | GCNSeqNo |
| FIASP | 077136 | GCNSeqNo |
| FIASP | 077137 | GCNSeqNo |
| FIASP | 077138 | GCNSeqNo |
| HUMALOG U-200 | 073403 | GCNSeqNo |
| HUMULIN N U-100 | 001740 | GCNSeqNo |
| HUMULIN N U-100 | 051292 | GCNSeqNo |
| HUMULIN R U-100 | 029916 | GCNSeqNo |
| HUMULIN R U-100 | 075447 | GCNSeqNo |
| INSULIN DEGLUDEC | 071842 | GCNSeqNo |
| INSULIN DEGLUDEC | 071843 | GCNSeqNo |
| INSULIN DEGLUDEC | 079385 | GCNSeqNo |
| INSULIN GLARGINE | 047780 | GCNSeqNo |
| INSULIN GLARGINE | 062867 | GCNSeqNo |
| LYUMJEV | 081183 | GCNSeqNo |
| LYUMJEV | 081186 | GCNSeqNo |
| LYUMJEV | 081187 | GCNSeqNo |
| NOVOLIN 70-30 | 016311 | GCNSeqNo |
| NOVOLIN 70-30 | 058952 | GCNSeqNo |
| NOVOLIN N U-100 | 001740 | GCNSeqNo |
| NOVOLIN N U-100 | 051292 | GCNSeqNo |
| NOVOLIN R U-100 | 001723 | GCNSeqNo |
| NOVOLIN R U-100 | 049833 | GCNSeqNo |
| SEMGLEE | 082542 | GCNSeqNo |
| SEMGLEE | 082541 | GCNSeqNo |
| SEMGLEE | 062867 | GCNSeqNo |
| SEMGLEE | 047780 | GCNSeqNo |
| REZVOGLAR | 082926 | GCNSeqNo |
| HUMALOG TEMPO | 034731 | GCNSeqNo |
|  | BASAGLAR TEMPO | 062867 | GCNSeqNo |
|  | LYUMJEV TEMPO | 081186 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 120 days with at least two preferred drugs having a similar duration of action?  If yes, please submit the medication trials and dates.  Please note: An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation. | Y | 1003 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1002 |
| 5 | 1002 |  | Select | Does the patient have a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)? | Y | 1003 |
| N | 1235 |
| 6 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | 1005 |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1005 |
| N | 1235 |
| 8 | 1005 |  | Select | Is the request for generic insulin glargine, generic insulin glargine-yfgn, brand Semglee, or generic insulin degludec? | Y | 1006 |
| N | 1008 |
| 9 | 1006 |  | Select | What medication is being requested? | Generic insulin glargine | 1007 |
| Generic insulin glargine-yfgn | 1007 |
| Brand Semglee | END (Approve x 365 Days) |
| Generic insulin degludec | 1007 |
| Other | 1235 |
| 10 | 1007 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | END (Approve x 365 Days) |
| N | 1235 |
| 11 | 1008 |  | Select | Is the request for any of the following: Basaglar Tempo Pen, Humalog Tempo Pen, or Lyumjev Tempo Pen? | Y | 1009 |
| N | END (Approve x 365 days) |
| 12 | 1009 |  | Select and Free Text | Has the patient had an inadequate clinical response or documentation submitted to support medical necessity beyond convenience for why the patient cannot use the corresponding FlexPens or Kwikpens?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 13 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 14 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/11/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Diabetes – Insulin | | |
| **Criteria Subtitle** | Afrezza | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AFREZZA | 073242 | GCNSeqNo |
| AFREZZA | 073243 | GCNSeqNo |
| AFREZZA | 073246 | GCNSeqNo |
| AFREZZA | 074308 | GCNSeqNo |
| AFREZZA | 076973 | GCNSeqNo |
| AFREZZA | 079460 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 120 days with at least two preferred drugs having a similar duration of action?  If yes, please submit the medication trials and dates.  Please note: An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation. | Y | 1003 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1002 |
| 5 | 1002 |  | Select | Does the patient have a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)? | Y | 1003 |
| N | 1235 |
| 6 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | 1005 |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1005 |
| N | 1235 |
| 8 | 1005 |  | Select and Free Text | Has the provider submitted documentation of the patient’s spirometry testing prior to initiation with a predicted FEV1 greater than or equal to 70 percent?  If yes, please submit documentation. | Y | 1006 |
| N | 1235 |
| 9 | 1006 |  | Select | Does the patient have Asthma or Chronic Obstructive Pulmonary Disease (COPD)? | Y | 1235 |
| N | 1007 |
| 10 | 1007 |  | Select and Free Text | Has the provider submitted documentation of the patient being nicotine-free for at least 180 days?  If yes, please submit documentation. | Y | END (Approve x 365 Days) |
| N | 1235 |
| 11 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 12 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/11/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Diabetes – Insulin | | |
| **Criteria Subtitle** | Step Therapy Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| TRESIBA | 071842 | GCNSeqNo |
| TRESIBA | 071843 | GCNSeqNo |
| TRESIBA | 079385 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 120 days with at least one preferred drug having a similar duration of action?  If yes, please submit the medication trials and dates.  Please note: An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation. | Y | END (Approve x 365 Days) |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | END (Approve x 365 Days) |
| N | 1002 |
| 5 | 1002 |  | Select | Does the patient have a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 6 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 Days) |
| N | 1235 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 8/11/2023 |
| **Other** |  |