**Endocrine Agents: Diabetes – Non-Insulin**

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| Criteria 1 | NP Agents- Adlyxin, Alogliptin, Bydureon Bcise, Glucophage, Metformin ER (Generic of Fortamet, Glumetza), Metformin Sol, Mounjaro, Onglyza, Ozempic, Rybelsus, Steglatro, Symlinpen |
| Criteria 2 | NP Agents – Combination Agents- Alogliptin/Metformin, Glimepiride/Pioglitazone, Glyxambi, Invokamet XR, Jentadueto XR, Kombiglyze XR, Pioglitazone/Alogliptin, Qtern, Segluromet, Soliqua, Steglujan, Synjardy XR, Trijardy XR, Xigduo XR, Xultophy |

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| **Criteria Title** | Endocrine Agents: Diabetes – Non-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) |
| ADLYXIN | 071734 | GCNSeqNo |
| ADLYXIN | 071735 | GCNSeqNo |
| ALOGLIPTIN | 070517 | GCNSeqNo |
| ALOGLIPTIN | 070524 | GCNSeqNo |
| ALOGLIPTIN | 070525 | GCNSeqNo |
| BYDUREON BCISE | 077890 | GCNSeqNo |
| GLUCOPHAGE | 013318 | GCNSeqNo |
| GLUCOPHAGE | 016441 | GCNSeqNo |
| GLUCOPHAGE | 040974 | GCNSeqNo |
| GLUCOPHAGE | 046754 | GCNSeqNo |
| GLUCOPHAGE | 052080 | GCNSeqNo |
| METFORMIN ER (Gen of Fortamet) | 061267 | GCNSeqNo |
| METFORMIN ER (Gen of Fortamet) | 061273 | GCNSeqNo |
| METFORMIN ER (Gen of Fortamet) | 054018 | GCNSeqNo |
| METFORMIN ER (Gen of Fortamet) | 054019 | GCNSeqNo |
| METFORMIN ER (Gen of Glumetza) | 061267 | GCNSeqNo |
| METFORMIN ER (Gen of Glumetza) | 061273 | GCNSeqNo |
| METFORMIN SOL | 053351 | GCNSeqNo |
| METFORMIN SOL | 080166 | GCNSeqNo |
| MOUNJARO | 083388 | GCNSeqNo |
| MOUNJARO | 083389 | GCNSeqNo |
| MOUNJARO | 083390 | GCNSeqNo |
| MOUNJARO | 083391 | GCNSeqNo |
| MOUNJARO | 083392 | GCNSeqNo |
| MOUNJARO | 083393 | GCNSeqNo |
| ONGLYZA | 065430 | GCNSeqNo |
| ONGLYZA | 065431 | GCNSeqNo |
| OZEMPIC | 077985 | GCNSeqNo |
| OZEMPIC | 077986 | GCNSeqNo |
| OZEMPIC | 081168 | GCNSeqNo |
| OZEMPIC | 083225 | GCNSeqNo |
| RYBELSUS | 080228 | GCNSeqNo |
| RYBELSUS | 080229 | GCNSeqNo |
| RYBELSUS | 080230 | GCNSeqNo |
| STEGLATRO | 078041 | GCNSeqNo |
| STEGLATRO | 078042 | GCNSeqNo |
| SYMLINPEN | 063735 | GCNSeqNo |
| SYMLINPEN | 063804 | 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 three preferred drugs?  If yes, please submit the medication trials and dates.  Please note: For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least one inadequate clinical response with a drug in same drug class.  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 and Free Text | Does the patient have a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| 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 Metformin ER (Generic of Fortamet, Glumetza)? | Y | 1006 |
| N | END (Pending Manual Review) |
| 9 | 1006 |  | Select | What strength is being requested? | Metformin HCl SR Tab 500 MG | 1007 |
| Metformin HCl SR Tab (**all strengths excluding 500 MG**) | 1008 |
| 10 | 1007 |  | Select | Ohio Medicaid covers up to 408 tablets per 102 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 11 | 1008 |  | Select | Ohio Medicaid covers up to 204 tablets per 102 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 12 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 13 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 14 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/18/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Diabetes – Non-Insulin | | |
| **Criteria Subtitle** | Non-Preferred Combination Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ALOGLIPTIN/METFORMIN | 070526 | GCNSeqNo |
| ALOGLIPTIN/METFORMIN | 070527 | GCNSeqNo |
| GLIMEPIRIDE/PIOGLITAZONE | 061388 | GCNSeqNo |
| GLIMEPIRIDE/PIOGLITAZONE | 061389 | GCNSeqNo |
| GLYXAMBI | 073432 | GCNSeqNo |
| GLYXAMBI | 073433 | GCNSeqNo |
| INVOKAMET XR | 076620 | GCNSeqNo |
| INVOKAMET XR | 076621 | GCNSeqNo |
| INVOKAMET XR | 076622 | GCNSeqNo |
| INVOKAMET XR | 076623 | GCNSeqNo |
| JENTADUETO XR | 076256 | GCNSeqNo |
| JENTADUETO XR | 076257 | GCNSeqNo |
| KOMBIGLYZE XR | 066816 | GCNSeqNo |
| KOMBIGLYZE XR | 066817 | GCNSeqNo |
| KOMBIGLYZE XR | 066818 | GCNSeqNo |
| PIOGLITAZONE/ALOGLIPTIN | 070518 | GCNSeqNo |
| PIOGLITAZONE/ALOGLIPTIN | 070519 | GCNSeqNo |
| PIOGLITAZONE/ALOGLIPTIN | 070520 | GCNSeqNo |
| PIOGLITAZONE/ALOGLIPTIN | 070522 | GCNSeqNo |
| QTERN | 077192 | GCNSeqNo |
| QTERN | 079873 | GCNSeqNo |
| SEGLUROMET | 078051 | GCNSeqNo |
| SEGLUROMET | 078052 | GCNSeqNo |
| SEGLUROMET | 078053 | GCNSeqNo |
| SEGLUROMET | 078054 | GCNSeqNo |
| SOLIQUA | 076864 | GCNSeqNo |
| STEGLUJAN | 078036 | GCNSeqNo |
| STEGLUJAN | 078037 | GCNSeqNo |
| SYNJARDY XR | 076940 | GCNSeqNo |
| SYNJARDY XR | 076941 | GCNSeqNo |
| SYNJARDY XR | 076942 | GCNSeqNo |
| SYNJARDY XR | 076943 | GCNSeqNo |
| TRIJARDY XR | 080710 | GCNSeqNo |
| TRIJARDY XR | 080711 | GCNSeqNo |
| TRIJARDY XR | 080712 | GCNSeqNo |
| TRIJARDY XR | 080713 | GCNSeqNo |
| XIGDUO XR | 073029 | GCNSeqNo |
| XIGDUO XR | 073030 | GCNSeqNo |
| XIGDUO XR | 073031 | GCNSeqNo |
| XIGDUO XR | 073032 | GCNSeqNo |
| XIGDUO XR | 078062 | GCNSeqNo |
| XULTOPHY | 073919 | 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 three preferred drugs?  If yes, please submit the medication trials and dates.  Please note: For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least one inadequate clinical response with a drug in same drug class.  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 and Free Text | Does the patient have a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1003 |  | Select and Free Text | Has the patient had a trial of at least 120 days with the individual drugs?  If yes, please submit the medication trials and dates. | Y | 1005 |
| N | 1004 |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for patient’s inability to use the individual drugs?  If yes, please submit the medication name and reason for inability to use. | Y | 1005 |
| N | 1236 |
| 8 | 1005 |  | 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 | 1006 |
| N | END (Pending Manual Review) |
| 9 | 1006 |  | 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 | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/18/2023 |
| **Other** |  |

Endocrine Agents: Diabetes-Non-Insulin

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| Class | Preferred Agents | Non-Preferred Agents |
| Alpha-Glucosidase Inhibitor | Acarbose, Miglitol |  |
| Amylinomimetic |  | Symlinpen |
| Biguanide | Metformin IR, Metformin ER (Generic of Glucophage XR) | Glucophage, Metformin ER (Generic of Fortamet, Glumetza), Metformin Sol |
| Dipeptidyl Peptidase 4 (DPP-4) Inhibitor | Januvia, Tradjenta | Alogliptin, Onglyza |
| Glucagon-Like Peptide-1 Receptor Agonist (GLP-1) | Byetta, Trulicity, Victoza | Adlyxin, Bydureon Bcise, Mounjaro, Ozempic, Rybelsus |
| Meglitinide | Nateglinide, Repaglinide |  |
| Sodium-Glucose Cotransporter 2 (SGLT-2) Inhibitor | Farxiga, Invokana, Jardiance | Steglatro |
| Sulfonylurea | Glimepiride, Glipizide, Glyburide |  |
| Thiazolidinedione | Pioglitazone |  |
| Combinations | | |
| Biguanide + DPP-4 Inhibitor | Janumet, Janumet XR, Jentadueto | Alogliptin/Metformin, Jentadueto XR, Kombiglyze XR |
| Biguanide + DPP-4 Inhibitor + SGLT-2 Inhibitor |  | Trijardy XR |
| Biguanide + Meglitinide | Repaglinide/Metformin |  |
| Biguanide + SGLT-2 Inhibitor | Invokamet, Synjardy | Invokamet XR, Segluromet, Synjardy XR, Xigduo XR |
| Biguanide + Sulfonylurea | Glipizide/Metformin, Glyburide/Metformin |  |
| Biguanide + Thiazolidinedione | Actoplus Met XR, Pioglitazone/Metformin |  |
| DPP-4 Inhibitor + SGLT-2 Inhibitor |  | Glyxambi, Qtern, Steglujan |
| DPP-4 Inhibitor + Thiazolidinedione |  | Pioglitazone/Alogliptin |
| GLP-1 Receptor Agonist + Insulin |  | Soliqua, Xultophy |
| Sulfonylurea + Thiazolidinedione |  | Glimepiride/Pioglitazone |