BlueCross BlueShield of Illinois
BlueCross BlueShield of Montana
BlueCross BlueShield of New Mexico
BlueCross BlueShield of Oklahoma
BlueCross BlueShield of Texas

Sodium-glucose Co-transporter (SGLT) Inhibitors and Combinations Step Therapy with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date **Date of Origin**
03-15-2025

POLICY AGENT SUMMARY STEP THERAPY

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Bexagliflozin ; Brenzavvy		20 MG	M ; N ; O	M		
Dapagliflozin propanediol ; Xigduo xr		10-1000 MG ; 10-500 MG ; 2.5-1000 MG ; 5-1000 MG ; 5-500 MG	M ; N ; O	M ; N		
Glyxambi		10-5 MG ; 25-5 MG	M ; N ; O	N		
Inpefa		200 MG ; 400 MG	M ; N ; O	N		
Invokamet ; Invokamet xr		150-1000 MG ; 150-500 MG ; 50-1000 MG ; 50-500 MG	M ; N ; O	N		
Qtern		10-5 MG ; 5-5 MG	M ; N ; O	N		
Segluromet		2.5-1000 MG ; 2.5-500 MG ; 7.5-1000 MG ; 7.5-500 MG	M ; N ; O	N		
Steglatro		15 MG ; 5 MG	M ; N ; O	N		
Steglujan		15-100 MG ; 5-100 MG	M ; N ; O	N		
Synjardy ; Synjardy xr		10-1000 MG ; 12.5-1000 MG ; 12.5-500 MG ; 25-1000 MG ; 5-1000 MG ; 5-500 MG	M ; N ; O	N		
Trijardy xr		10-5-1000 MG ; 12.5-2.5-1000 MG ; 25-5-1000 MG ; 5-2.5-1000 MG	M ; N ; O	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Bexagliflozin ; Brenzavvy	bexagliflozin tab	20 MG	30	Tablets	30	DAYS			
Dapagliflozin propanediol ; Farxiga	dapagliflozin propanediol tab	10 MG ; 5 MG	30	Tablets	30	DAYS			
Dapagliflozin propanediol ; Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 10-1000 MG	10-1000 MG	30	Tablets	30	DAYS			
Dapagliflozin propanediol ; Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 5-1000 MG	5-1000 MG	60	Tablets	30	DAYS			
Glyxambi	empagliflozin-linagliptin tab	10-5 MG ; 25-5 MG	30	Tablets	30	DAYS			
Inpefa	sotagliflozin tab	200 MG	30	Tablets	30	DAYS			
Inpefa	sotagliflozin tab	400 MG	30	Tablets	30	DAYS			
Invokamet	canagliflozin-metformin hcl tab	150-1000 MG ; 150-500 MG ; 50-1000 MG ; 50-500 MG	60	Tablets	30	DAYS			
Invokamet xr	canagliflozin-metformin hcl tab er	150-1000 MG ; 150-500 MG ; 50-1000 MG ; 50-500 MG	60	Tablets	30	DAYS			
Invokana	canagliflozin tab	100 MG ; 300 MG	30	Tablets	30	DAYS			
Jardiance	empagliflozin tab	10 MG ; 25 MG	30	Tablets	30	DAYS			
Qtern	Dapagliflozin-Saxagliptin Tab 10-5 MG	10-5 MG	30	Tablets	30	DAYS			
Qtern	Dapagliflozin-Saxagliptin Tab 5-5 MG	5-5 MG	30	Tablets	30	DAYS			
Segluromet	Ertugliflozin-Metformin HCl Tab 2.5-1000 MG	2.5-1000 MG	60	Tablets	30	DAYS			
Segluromet	Ertugliflozin-Metformin HCl Tab 2.5-500 MG	2.5-500 MG	120	Tablets	30	DAYS			
Segluromet	Ertugliflozin-Metformin HCl Tab 7.5-1000 MG	7.5-1000 MG	60	Tablets	30	DAYS			
Segluromet	Ertugliflozin-Metformin HCl Tab 7.5-500 MG	7.5-500 MG	60	Tablets	30	DAYS			
Steglatro	Ertugliflozin L-Pyroglutamic Acid Tab 15 MG (Base Equiv)	15 MG	30	Tablets	30	DAYS			
Steglatro	Ertugliflozin L-Pyroglutamic Acid	5 MG	60	Tablets	30	DAYS			

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
	Tab 5 MG (Base Equiv)								
Steglujan	Ertugliflozin-Sitagliptin Tab 15-100 MG	15-100 MG	30	Tablets	30	DAYS			
Steglujan	Ertugliflozin-Sitagliptin Tab 5-100 MG	5-100 MG	30	Tablets	30	DAYS			
Synjardy	empagliflozin-metformin hcl tab	12.5-1000 MG ; 12.5-500 MG ; 5-1000 MG ; 5-500 MG	60	Tablets	30	DAYS			
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 10-1000 MG	10-1000 MG	60	Tablets	30	DAYS			
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 12.5-1000 MG	12.5-1000 MG	60	Tablets	30	DAYS			
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 25-1000 MG	25-1000 MG	30	Tablets	30	DAYS			
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 5-1000 MG	5-1000 MG	60	Tablets	30	DAYS			
Trijardy xr	empagliflozin-linaglip-metformin tab er	12.5-2.5-1000 MG	60	Tablets	30	DAYS			
Trijardy xr	Empagliflozin-Linagliptin-Metformin Tab ER 24HR 10-5-1000 MG	10-5-1000 MG	30	Tablets	30	DAYS			
Trijardy xr	Empagliflozin-Linagliptin-Metformin Tab ER 24HR 25-5-1000 MG	25-5-1000 MG	30	Tablets	30	DAYS			
Trijardy xr	Empagliflozin-Linagliptin-Metformin Tab ER 24HR 5-2.5-1000MG	5-2.5-1000 MG	60	Tablets	30	DAYS			
Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 10-500 MG	10-500 MG	30	Tablets	30	DAYS			
Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 2.5-1000 MG	2.5-1000 MG	60	Tablets	30	DAYS			
Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 5-500 MG	5-500 MG	30	Tablets	30	DAYS			

CLIENT SUMMARY – STEP THERAPY

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Bexagliflozin ; Brenzavvy		20 MG	BCBSIL Medicaid
Dapagliflozin propanediol ; Xigduo xr		10-1000 MG ; 10-500 MG ; 2.5-1000 MG ; 5-1000 MG ; 5-500 MG	BCBSIL Medicaid
Glyxambi		10-5 MG ; 25-5 MG	BCBSIL Medicaid
Inpefa		200 MG ; 400 MG	BCBSIL Medicaid
Invokamet ; Invokamet xr		150-1000 MG ; 150-500 MG ; 50-1000 MG ; 50-500 MG	BCBSIL Medicaid
Qtern		10-5 MG ; 5-5 MG	BCBSIL Medicaid
Segluromet		2.5-1000 MG ; 2.5-500 MG ; 7.5-1000 MG ; 7.5-500 MG	BCBSIL Medicaid
Steglatro		15 MG ; 5 MG	BCBSIL Medicaid ; BCBSNM Medicaid
Steglujan		15-100 MG ; 5-100 MG	BCBSIL Medicaid
Synjardy ; Synjardy xr		10-1000 MG ; 12.5-1000 MG ; 12.5-500 MG ; 25-1000 MG ; 5-1000 MG ; 5-500 MG	BCBSIL Medicaid
Trijardy xr		10-5-1000 MG ; 12.5-2.5-1000 MG ; 25-5-1000 MG ; 5-2.5-1000 MG	BCBSIL Medicaid

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Bexagliflozin ; Brenzavvy	bexagliflozin tab	20 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Dapagliflozin propanediol ; Farxiga	dapagliflozin propanediol tab	10 MG ; 5 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Dapagliflozin propanediol ; Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 10-1000 MG	10-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Dapagliflozin propanediol ; Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 5-1000 MG	5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Glyxambi	empagliflozin-linagliptin tab	10-5 MG ; 25-5 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Inpefa	sotagliflozin tab	200 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Inpefa	sotagliflozin tab	400 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Invokamet	canagliflozin-metformin hcl tab	150-1000 MG ; 150-500 MG ; 50-1000 MG ; 50-500 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Invokamet xr	canagliflozin-metformin hcl tab er	150-1000 MG ; 150-500 MG ; 50-1000 MG ; 50-500 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Invokana	canagliflozin tab	100 MG ; 300 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Jardiance	empagliflozin tab	10 MG ; 25 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Qtern	Dapagliflozin-Saxagliptin Tab 10-5 MG	10-5 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Qtern	Dapagliflozin-Saxagliptin Tab 5-5 MG	5-5 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Segluromet	Ertugliflozin-Metformin HCl Tab 2.5-1000 MG	2.5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Segluromet	Ertugliflozin-Metformin HCl Tab 2.5-500 MG	2.5-500 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Segluromet	Ertugliflozin-Metformin HCl Tab 7.5-1000 MG	7.5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Segluromet	Ertugliflozin-Metformin HCl Tab 7.5-500 MG	7.5-500 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Steglatro	Ertugliflozin L-Pyroglutamic Acid Tab 15 MG (Base Equiv)	15 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Steglatro	Ertugliflozin L-Pyroglutamic Acid Tab 5 MG (Base Equiv)	5 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Steglujan	Ertugliflozin-Sitagliptin Tab 15-100 MG	15-100 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Steglujan	Ertugliflozin-Sitagliptin Tab 5-100 MG	5-100 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Synjardy	empagliflozin-metformin hcl tab	12.5-1000 MG ; 12.5-500 MG ; 5-1000 MG ; 5-500 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 10-1000 MG	10-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 12.5-1000 MG	12.5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 25-1000 MG	25-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Synjardy xr	Empagliflozin-Metformin HCl Tab ER 24HR 5-1000 MG	5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Trijardy xr	empagliflozin-linaglip-metformin tab er	12.5-2.5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Trijardy xr	Empagliflozin-Linagliptin-Metformin Tab ER 24HR 10-5-1000 MG	10-5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Trijardy xr	Empagliflozin-Linagliptin-Metformin Tab ER 24HR 25-5-1000 MG	25-5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Trijardy xr	Empagliflozin-Linagliptin-Metformin Tab ER 24HR 5-2.5-1000MG	5-2.5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 10-500 MG	10-500 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 2.5-1000 MG	2.5-1000 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid
Xigduo xr	Dapagliflozin-Metformin HCl Tab ER 24HR 5-500 MG	5-500 MG	BCBSIL Medicaid ; BCBSNM Medicaid ; BCBSTX Medicaid

STEP THERAPY CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
All other target agent(s)	**TARGET AGENT(S)** **Brenzavvy, Bexagliflozin** **Glyxambi** (empagliflozin/linagliptin) **Invokamet** (canagliflozin/metformin) **Invokamet XR** (canagliflozin/metformin ER) **Qtern** (dapagliflozin/saxagliptin) **Segluromet** (ertugliflozin/metformin) **Steglatro** (ertugliflozin) **Steglujan** (ertugliflozin/sitagliptin) **Synjardy** (empagliflozin/metformin) **Synjardy XR** (empagliflozin/metformin ER) **Trijardy XR** (empagliflozin/linagliptin/metformin ER) **All other target agent(s)** will be approved when ONE of the following is met: 1. The patient has a diagnosis of type 2 diabetes with or at high risk for atherosclerotic cardiovascular disease, heart failure, and/or chronic kidney disease **OR** 2. BOTH of the following: A. The patient's medication history includes use of an agent containing metformin or insulin in the past 120 days **AND** B. If the patient has previously tried metformin, the patient's dose of metformin has been optimized to a daily dose of 1000-2000 mg **OR** 3. The patient has an intolerance or hypersensitivity to metformin or insulin **OR** 4. The patient has an FDA labeled contraindication to BOTH metformin and insulin **OR** 5. The prescriber states the patient is currently being treated with the requested SGLT inhibitor within the past 120 days AND is at risk if therapy is changed **OR** 6. The patient is currently being treated with the requested SGLT inhibitor OR any other SGLT inhibitor within the past 120 days **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.
Inpefa	**TARGET AGENT(S)** **Inpefa** (sotagliflozin) **Inpefa** will be approved when ONE of the following is met: 1. The patient has a diagnosis of heart failure **OR** 2. The patient has a diagnosis of type 2 diabetes with or at high risk for atherosclerotic cardiovascular disease, heart failure, and/or chronic kidney disease **OR** 3. BOTH of the following: A. The patient's medication history includes use of an agent containing metformin or insulin in the past 120 days **AND** B. If the patient has previously tried metformin, the patient's dose of metformin has been optimized to a daily dose of 1000-2000 mg **OR** 4. The patient's medication history includes use of an agent containing ACE inhibitors, angiotensin receptor blockers (ARBs), angiotensin receptor-neprilysin inhibitors (ARNIs), I_f channel inhibitors (e.g., Corlanor), aldosterone antagonists, beta blockers, isosorbide dinitrate or hydralazine in the past 120 days **OR** 5. The patient has an intolerance or hypersensitivity to metformin or insulin **OR** 6. The patient has an FDA labeled contraindication to BOTH metformin and insulin **OR** 7. The patient has an intolerance or hypersensitivity to ONE of the following agents: ACE inhibitors, angiotensin receptor blockers (ARBs), angiotensin receptor-neprilysin inhibitors (ARNIs),

Module	Clinical Criteria for Approval
	I_f channel inhibitors (e.g., Corlanor), aldosterone antagonists, beta blockers, isosorbide dinitrate or hydralazine **OR** 8. The patient has an FDA labeled contraindication to ALL of the following agents: ACE inhibitors, angiotensin receptor blockers (ARBs), angiotensin receptor-neprilysin inhibitors (ARNIs), I_f channel inhibitors (e.g., Corlanor), aldosterone antagonists, beta blockers, isosorbide dinitrate and hydralazine 9. The prescriber states the patient is currently being treated with the requested SGLT inhibitor within the past 120 days AND is at risk if therapy is changed **OR** 10. The patient is currently being treated with the requested SGLT inhibitor OR any other SGLT inhibitor within the past 120 days **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.
Xigduo XR	**TARGET AGENT(S)** **Xigduo XR™** (dapagliflozin/metformin ER) **Xigduo XR** will be approved when ONE of the following is met: 1. The patient has a diagnosis of heart failure **OR** 2. The patient has a diagnosis of type 2 diabetes with or at high risk for atherosclerotic cardiovascular disease, heart failure, and/or chronic kidney disease **OR** 3. The patient has a diagnosis of chronic kidney disease (CKD) **OR** 4. BOTH of the following: A. The patient's medication history includes use of an agent containing metformin or insulin in the past 120 days **AND** B. If the patient has previously tried metformin, the patient's dose of metformin has been optimized to a daily dose of 1000-2000 mg **OR** 5. The patient's medication history includes use of an agent containing ACE inhibitors, angiotensin receptor blockers (ARBs), angiotensin receptor-neprilysin inhibitors (ARNIs), I_f channel inhibitors (e.g., Corlanor), aldosterone antagonists, beta blockers, isosorbide dinitrate or hydralazine in the past 120 days **OR** 6. The patient has an intolerance or hypersensitivity to metformin or insulin **OR** 7. The patient has an FDA labeled contraindication to BOTH metformin and insulin **OR** 8. The patient has an intolerance or hypersensitivity to ONE of the following agents: ACE inhibitors, angiotensin receptor blockers (ARBs), angiotensin receptor-neprilysin inhibitors (ARNIs), I_f channel inhibitors (e.g., Corlanor), aldosterone antagonists, beta blockers, isosorbide dinitrate or hydralazine **OR** 9. The patient has an FDA labeled contraindication to ALL of the following agents: ACE inhibitors, angiotensin receptor blockers (ARBs), angiotensin receptor-neprilysin inhibitors (ARNIs), I_f channel inhibitors (e.g., Corlanor), aldosterone antagonists, beta blockers, isosorbide dinitrate and hydralazine **OR** 10. The prescriber states the patient is currently being treated with the requested SGLT inhibitor within the past 120 days AND is at risk if therapy is changed **OR** 11. The patient is currently being treated with the requested SGLT inhibitor OR any other SGLT inhibitor within the past 120 days **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR**

Module	Clinical Criteria for Approval
	2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: A. BOTH of the following: 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication **AND** 2. There is support for therapy with a higher dose for the requested indication **OR** B. BOTH of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit **OR** C. BOTH of the following: 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication **AND** 2. There is support for therapy with a higher dose for the requested indication **Length of Approval**: 12 months