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Sodium-Glucose CoTransporter-2 Inhibitors (SGLT-2 Inhibitors) Drug Use Criteria

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Includes:

Brenzavvy ©	**Bexagliflozin**
Steglatro©	**Ertugliflozin Pidolate**
Dapagliflozin	**Dapagliflozin (PA required, qualifying diagnosis)**
Jardiance ©	**Empagliflozin (PA required, qualifying diagnosis, step therapy)**
Invokana ©	**Canagliflozin (PA required, qualifying diagnosis, step therapy)**

Not preferred:

Inpefa©	Sotagliflozin
Invokamet XR©	Canagliflozin/Metformin HCl
Invokamet©	Canagliflozin/Metformin HCl
XigduoXR©	Dapagliflozin/Metformin HCl
Qtern©	Dapagliflozin/Saxagliptin HCl
Glyxambi©	Empagliflozin/Linagliptin
Synjardy XR©	Empagliflozin/Metformin HCl
Synjardy©	Empagliflozin/Metformin HCl
Segluromet©	Ertugliflozin/Metformin
Steglujan©	Ertugliflozin/Sitagliptin
Trijardy XR©	Empaglifozin/Linagliptin/metformin

(Bolded items are preferred agents)

GUIDELINE FOR USE:

1. Does the member have one of the following diagnoses?
    - Chronic Kidney Disease (CKD) (eGFR 25–60 mL/min/1.73 m^2 OR urinary albumin-to-creatinine ratio ≥200 mg/g), OR
    - Heart Failure with Reduced Ejection Fraction (HFrEF), OR
    - Established ASCVD

    a. If yes, go to 2
    b. If no, go to 5

2. Is the request for dapagliflozin?
    a. If yes, approve up to 12 months
    b. If no, go to 3

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3. Is the request for empagliflozin or canagliflozin?
    a. If yes, go to 4
    b. If no, deny as not meeting criteria. Step therapy with dapagliflozin (first line) and empagliflozin (second line) is required.

4. Has the member used dapagliflozin for at least 90 days with documentation of no clinical benefit or with a contraindication or intolerance
    a. If yes, approve for up to 12 months
    b. If no, deny as not meeting criteria. Step therapy with dapagliflozin is required.

5. Has the member trialed and failed, or have contraindications to preferred first line formulary product Brenzavvy© (bexagliflozin) or Steglatro © (ertugliflozin)?
    a. If yes, approve up to 12 months
    b. If no, deny as not meeting criteria. Preferred formulary options must be used prior to other SGLT-2 inhibitors unless contraindicated.

Rationale:
To promote value within step therapy management and evidence-based standard of care. To ensure optimization of least costly formulary alternative, metformin. Adherence and dose optimization will be reviewed using prescription refill history for consideration of coverage for SGLT-2 inhibitors.

FDA Approved Indication:

As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus for all products. See Table 1 for medication specific indications.

References:

1. American Diabetes Association. Standards of Medical Care in Diabetes—2024. Diabetes Care. 2024;47(Suppl 1):S1–S210.
2. Heerspink HJL, et al. Dapagliflozin in Patients with Chronic Kidney Disease. N Engl J Med. 2020;383:1436–1446.
3. McMurray JJV, et al. Dapagliflozin in Patients with Heart Failure and Reduced Ejection Fraction. N Engl J Med. 2019;381:1995–2008.
4. Zinman B, et al. Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes. N Engl J Med. 2015;373:2117–2128.
5. FDA Prescribing Information: Brenzavvy (bexagliflozin), Steglatro (ertugliflozin), Farxiga (dapagliflozin), Jardiance (empagliflozin).
6. KDIGO Clinical Practice Guideline for Diabetes Management in CKD: 2022 Update.