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Bridging the Future of Healthcare

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

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Reviewed: September 30, 2020, October 2020, September 2021, January 2022, February 2022, July

2022, September 2023, October 2023, April 2025

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

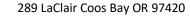
Invokamet XR© Canagliflozin/Metformin HCI Invokamet© Canagliflozin/Metformin HCI XigduoXR© Dapagliflozin/Metformin HCI **Qtern**© Dapagliflozin/Saxagliptin HCI Glyxambi@ Empagliflozin/Linagliptin Synjardy XR© Empagliflozin/Metformin HCI Empagliflozin/Metformin HCI Synjardy© Segluromet© Ertugliflozin/Metformin **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 m² 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.