

## Clinical Policy: Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

Reference Number: OR.CP.PMN.03

Effective Date: 01.01.22

Last Review Date: 01.23

Line of Business: Medicaid – Trillium Oregon Health Plan

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

The following agents contain a dipeptidyl peptidase-4 (DPP-4) inhibitor and require prior authorization\*: linagliptin (Tradjenta<sup>®</sup>), linagliptin/metformin (Jentadueto<sup>®</sup>, Jentadueto<sup>®</sup> XR), saxagliptin (Onglyza<sup>®</sup>), saxagliptin/metformin (Kombiglyze<sup>®</sup> XR), sitagliptin (Januvia<sup>®</sup>), and sitagliptin/metformin (Janumet<sup>®</sup>, Janumet<sup>®</sup> XR).

*\*If request is for a combination DPP-4 inhibitor and sodium glucose co-transporter 2 (SGLT2) inhibitor (e.g., linagliptin/empagliflozin [Glyxambi<sup>®</sup>], linagliptin/empagliflozin/metformin [Trijardy<sup>™</sup> XR], saxagliptin/dapagliflozin [Qtern<sup>®</sup>], sitagliptin/ertugliflozin [Steglujan<sup>™</sup>]), refer to OR.CP.PMN.14 SGLT Inhibitors.*

### FDA Approved Indication(s)

DPP-4 inhibitors are indicated as adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitation(s) of use:

- DPP-4 inhibitors should not be used in patients with type 1 diabetes.
- Onglyza and Kombiglyze should not be used for the treatment of diabetic ketoacidosis.
- Tradjenta, Jentadueto, Jentadueto XR, Januvia, Janumet, and Janumet XR have not been studied in patients with a history of pancreatitis.

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Trillium Community Health Plan that DPP-4 inhibitors are **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Type 2 Diabetes Mellitus (must meet all):

1. Diagnosis of type 2 diabetes mellitus;
2. Age  $\geq$  18 years;
3. Member meets one of the following (a, b, c or d):
  - a. Failure of  $\geq$  3 consecutive months of metformin;
  - b. Use of metformin is contraindicated or clinically significant adverse effects were previously experienced;

- c. For antidiabetic medication-naïve members, requested agent is approvable if intended for concurrent use with metformin due to HbA1c  $\geq$  8.5% (drawn within the past 3 months);
- d. History of  $\geq$  3 consecutive months insulin use and at high ASCVD risk (age  $\geq$  55 years with coronary carotid, lower extremity artery stenosis  $>$  50%, or LVH);
4. Failure of  $\geq$  3 consecutive months of an alogliptin-containing product (e.g., alogliptin [Nesina<sup>®</sup>], alogliptin/metformin [Kazano<sup>®</sup>], alogliptin/pioglitazone [Oseni<sup>®</sup>]), unless clinically significant adverse effects are experienced or all are contraindicated;
5. Dose does not exceed the FDA approved maximum recommended dose (*see Section V*).

**Approval duration: 12 months**

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Type 2 Diabetes Mellitus (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose (*see Section V*).

**Approval duration: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 12 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

AACE: American Association of Clinical Endocrinologists

ACE: American College of Endocrinology

ADA: American Diabetes Association

DPP-4: dipeptidyl peptidase-4

FDA: Food and Drug Administration

GLP-1: glucagon-like peptide-1

HbA1c: glycated hemoglobin

SGLT2: sodium-glucose co-transporter 2

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
metformin (Fortamet <sup>®</sup> , Glucophage <sup>®</sup> , Glucophage <sup>®</sup> XR, Glumetza <sup>®</sup> )	Regular-release (Glucophage): 500 mg PO BID or 850 mg PO QD; increase as needed in increments of 500 mg/week or 850 mg every 2 weeks  Extended-release: <ul style="list-style-type: none"> <li>• Fortamet, Glumetza: 1,000 mg PO QD; increase as needed in increments of 500 mg/week</li> <li>• Glucophage XR: 500 mg PO QD; increase as needed in increments of 500 mg/week</li> </ul>	Regular-release: 2,550 mg/day  Extended-release: 2,000 mg/day
Nesina (alogliptin)	25 mg PO QD	25 mg/day
Kazano (alogliptin/metformin)	Individualized dose PO BID	25/2,000 mg/day
Oseni (alogliptin/pioglitazone)	Individualized dose PO QD	25/45 mg/day

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s):
  - History of serious hypersensitivity reaction to the requested drug product
  - Severe renal impairment (*metformin-containing products*) or moderate to severe renal impairment (*Qtern and Qternmet XR*)
  - Acute or chronic metabolic acidosis, including diabetic ketoacidosis (*metformin-containing products only*)
- Boxed warning(s): lactic acidosis (*metformin-containing products only*)

*Appendix D: General Information*

- Per the American Diabetes Association (ADA) and American Association of Clinical Endocrinologists and American College of Endocrinology (AAACE/ACE) guidelines:
  - Metformin is recommended for all patients with type 2 diabetes. It is effective and safe, is inexpensive, and may reduce risk of cardiovascular events and death. Monotherapy is recommended for most patients; however:
    - Starting with dual therapy (i.e., metformin plus another agent, such as a sulfonylurea, thiazolidinedione, DPP-4 inhibitor, SGLT2 inhibitor, glucagon-like

peptide 1 [GLP-1] receptor agonist, or basal insulin) may be considered for patients with baseline HbA1c  $\geq 1.5\%$  above their target. According to the ADA, a reasonable HbA1c target for many non-pregnant adults is  $< 7\%$  ( $\leq 6.5\%$  per the AACE/ACE).

- Starting with combination therapy with insulin may be considered for patients with baseline HbA1c  $> 10\%$  or if symptoms of hyperglycemia are present.
- If the target HbA1c is not achieved after approximately 3 months of monotherapy, dual therapy should be initiated. If dual therapy is inadequate after 3 months, triple therapy should be initiated. Finally, if triple therapy fails to bring a patient to goal, combination therapy with insulin should be initiated. Each non-insulin agent added to initial therapy can lower HbA1c by 0.7-1%.

## V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Janumet (sitagliptin/metformin)	Individualized dose PO BID	100/2,000 mg/day
Janumet XR (sitagliptin/metformin)	Individualized dose PO QD	100/2,000 mg/day
Januvia (sitagliptin)	100 mg PO QD	100 mg/day
Jentadueto (linagliptin/metformin)	Individualized dose PO BID	5/2,000 mg/day
Jentadueto XR (linagliptin/metformin)	Individualized dose PO QD	5/2,000 mg/day
Kombiglyze XR (saxagliptin/metformin)	Individualized dose PO QD	5/2,000 mg/day
Onglyza (saxagliptin)	2.5 or 5 mg PO QD	5 mg/day
Tradjenta (linagliptin)	5 mg PO QD	5 mg/day

## VI. Product Availability

Drug Name	Availability
Janumet (sitagliptin/metformin)	Tablets: 50/500 mg, 50/1,000 mg
Janumet XR (sitagliptin/metformin)	Tablets: 100/1,000 mg, 50/500 mg, 50/1,000 mg
Januvia (sitagliptin)	Tablets: 25 mg, 50 mg, 100 mg
Jentadueto (linagliptin/metformin)	Tablets: 2.5/500 mg, 2.5/850 mg, 2.5/1,000 mg
Jentadueto XR (linagliptin/metformin)	Tablets: 5/1,000 mg, 2.5/1,000 mg
Kombiglyze XR (saxagliptin/metformin)	Tablets: 5/500 mg, 5/1,000 mg, 2.5/1,000 mg
Onglyza (saxagliptin)	Tablets: 2.5 mg, 5 mg
Tradjenta (linagliptin)	Tablets: 5 mg

## VII. References

1. American Diabetes Association. Standards of medical care in diabetes—2022. *Diabetes Care*. 2022; 45(suppl 1): S1-S264. Updated May 2022. Accessed October 26, 2022.
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from previously approved policy TCHP.PHAR.2001 Dipeptidyl Peptidase-4 (DPP-4) Inhibitors. Removed criteria for combination DPP4/SGLT2 products and directed requests to the SGLT2 policy instead	09.21.21	10.21.21
1Q 2022 annual review: no significant changes; references reviewed and updated.	12.20.21	01.06.22
1Q 2023 annual review: no significant changes; references reviewed and updated.	12.14.22	01.06.23

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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