ANTIDIABETIC AGENTS: AMYLIN ANALOG (SYMLINPEN); SGLT2 INHIBITOR (BRENZAVVY, FARXIGA, INVOKANA, JARDIANCE, STEGLATRO); SGLT2 INHIBITOR/METFORMIN (INVOKAMET, INVOKAMET XR, SEGLUROMET, SYNJARDY, SYNJARDY XR, XIGDUO XR); SGLT2 INHIBITOR/DPP-4 INHIBITOR (GLYXAMBI, QTERN, STEGLUJAN); SGLT2 INHIBITOR/DPP-4 INHIBITOR/METFORMIN (TRIJARDY XR); LONG ACTING INSULIN/GLP-1 RECEPTOR AGONIST (SOLIQUA, XULTOPHY)

INITIAL STEP THERAPY*

**Include Rx and OTC products unless otherwise stated.*

INITIAL STEP THERAPY For AMYLIN ANALOGS (SymlinPen):
If the patient has filled a prescription for at least a 30-day supply of a rapid-acting insulin or short-acting insulin or pre-mixed insulin [e.g., insulin aspart (Novolog), insulin glulisine (Apidra), insulin lispro (Humalog), insulin regular R (Afrezza, Humulin R, Novolin R)] within the past 120 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

INITIAL STEP THERAPY For ALL OTHER TARGET DRUGS:

If the patient has filled a prescription for at least a 30-day supply of metformin within the past 180 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The request is not for a non-formulary product [Brenzavvy (bexagliflozin), Farxiga (dapagliflozin), Invokana (canagliflozin), Steglatro (ertugliflozin), Invokamet (canagliflozin/metformin), Invokamet XR (canagliflozin/metformin ER), Segluromet

(ertugliflozin/metformin), Xigduo XR (dapagliflozin/metformin), Qtern (dapagliflozin/saxagliptin), Steglujan (ertugliflozin/sitagliptin), Trijardy XR (empagliflozin/linagliptin/metformin ER)]

- The patient has a diagnosis of type 2 diabetes mellitus **AND**
  - The patient has NOT been receiving a stable maintenance dose of the requested drug for at least 3 months **AND**
    - The patient experienced an inadequate treatment response, intolerance, or has a contraindication to metformin

    OR

    - The patient requires combination therapy AND has an A1C of 7.5 percent or greater

    OR

    - The request is for Jardiance (empagliflozin) **AND** the patient has established cardiovascular disease **OR** heart failure **OR** chronic kidney disease at risk of progression

  OR

  - The patient has been receiving a stable maintenance dose of the requested drug for at least 3 months **AND**
    - The patient has demonstrated a reduction in A1C since starting this therapy

    OR

    - The request is for Jardiance (empagliflozin) **AND** the patient has established cardiovascular disease **OR** heart failure **OR** chronic kidney disease at risk of progression

OR

- The request is for SymlinPen (pramlintide acetate) AND the patient has a diagnosis of type 1 or type 2 diabetes mellitus **AND**
  - The patient has NOT been receiving a stable maintenance dose of the requested drug for at least 3 months **AND**
    - The patient has failed to achieve desired glucose control despite receiving optimal insulin therapy, including mealtime insulin

    OR

  - The patient has been receiving a stable maintenance dose of the requested drug for at least 3 months **AND**
    - The patient has demonstrated a reduction in A1C since starting this therapy

OR

- The request is for Jardiance (empagliflozin) **AND**
  - The patient has a diagnosis of heart failure **OR** chronic kidney disease at risk of progression