



**GEORGIA MEDICAID FEE-FOR-SERVICE  
ANTIDIABETIC AGENTS PA SUMMARY**

<b>Preferred Medications</b>	<b>Non-Preferred Medications</b>
<p><b><i>Preferred Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</i></b>            Jentadueto (linagliptin/metformin)*            Kombiglyze (saxagliptin/metformin)*            Onglyza (saxagliptin)*            Tradjenta (linagliptin)*</p> <p><b><i>Preferred Meglitinides</i></b>            Prandin (repaglinide)            Starlix (nateglinide)</p> <p><b><i>Preferred Metformin Products</i></b>            Metformin generic            Metformin ER generic            Riomet (metformin)</p> <p><b><i>Preferred Sulfonylureas</i></b>            Glimepiride generic            Glipizide generic            Glyburide generic</p> <p><b><i>Preferred Thiazolidinediones (TZD)</i></b>            Pioglitazone generic</p> <p><b><i>Preferred Miscellaneous Antidiabetic Agents</i></b>            Bydureon (exenatide ER)*            SymlinPen (pramlintide)*</p> <p><b><i>Preferred Alpha-Glucosidase Inhibitors</i></b>            Acarbose generic            Miglitol generic</p>	<p><b><i>Non-Preferred DPP-4 Inhibitors</i></b>            Alogliptin 6.25mg, 12.5mg generic            Alogliptin/metformin generic            Alogliptin/pioglitazone            Januvia (sitagliptin)            Janumet (sitagliptin/metformin)            Janumet XR (sitagliptin/metformin extended-release)            Jentadueto XR (linagliptin/metformin extended-release)            Nesina 25mg (alogliptin)</p> <p><b><i>Non-Preferred Meglitinides</i></b>            Nateglinide generic            Prandimet (repaglinide/metformin)            Repaglinide generic            Repaglinide/metformin generic</p> <p><b><i>Non-Preferred Metformin Products</i></b>            Fortamet ER (metformin SR 24hr)            Glumetza ER (metformin SR 24hr)            Metformin SR 24 hr (generic Fortamet ER)</p> <p><b><i>Non-Preferred Sodium-Glucose Co-Transporter 2 (SGT2) Inhibitors</i></b>            Farxiga (dapagliflozin)            Glyxambi (empagliflozin/linagliptin)            Invokamet (canagliflozin/metformin)            Invokana (canagliflozin)            Jardiance (empagliflozin)            Synjardy (empagliflozin/metformin)            Xigduo (dapagliflozin/metformin)</p> <p><b><i>Non-Preferred Sulfonylureas</i></b>            Chlorpropamide generic            Tolazamide generic            Tolbutamide generic</p> <p><b><i>Non-Preferred Thiazolidinediones (TZD)</i></b>            Actoplus Met XR (pioglitazone/metformin ER)            Avandia (rosiglitazone)            Avandamet (rosiglitazone/metformin)            Duetact (pioglitazone/glimepiride)            Pioglitazone/glimepiride generic            Pioglitazone/metformin generic</p> <p><b><i>Non-Preferred Miscellaneous Antidiabetic Agents</i></b>            Byetta (exenatide)            Cycloset (bromocriptine)            Tanzeum (albiglutide)*            Trulicity (dulaglutide)</p>



	Victoza (liraglutide)
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\*Preferred agents that require prior authorization (PA).

**LENGTH OF AUTHORIZATION:** Varies

**NOTES:**

- ❖ Insulins and Diabetic Supplies/Insulin Pens have separate PA criteria.
- ❖ Preferred and non-preferred DPP-4 Inhibitors and Miscellaneous Agents require prior authorization.
- ❖ If generic pioglitazone/glimepiride is approved, the PA will be issued for brand Duetact.
- ❖ If generic repaglinide/metformin is approved, the PA will be issued for brand Prandimet.

**PA CRITERIA:**

*Onglyza and Tradjenta*

- ❖ Approvable for members with type 2 diabetes mellitus
- AND
- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to metformin and either a thiazolidinedione or a sulfonylurea
- AND
- ❖ Submit documentation of hemoglobin A1c (HbA1c) results within the past 6 months.

*Jentaduo and Kombiglyze*

- ❖ Approvable for members with type 2 diabetes mellitus that are taking Onglyza or Tradjenta with metformin. Otherwise, the criteria above for Onglyza or Tradjenta must be met
- AND
- ❖ Submit documentation of hemoglobin A1c (HbA1c) results within the past 6 months.

*Alogliptin 6.25mg, 12.5mg Generic, Januvia and Nesina 25mg*

- ❖ Approvable for members with type 2 diabetes mellitus
- AND
- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to Onglyza and Tradjenta
- AND
- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.

*Alogliptin/Metformin Generic, Janumet and Janumet XR*

- ❖ Approvable for members with type 2 diabetes mellitus
- AND
- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to Jentaduo and Kombiglyze
- AND
- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.



*Alogliptin/Pioglitazone Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products generic pioglitazone and brand Nesina 25mg or generic alogliptin 6.25mg or 12.5mg as well as Onglyza and Tradjenta are not appropriate for the member.

*Jentadueto XR*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Jentadueto and generic metformin ER, are not appropriate for the member.

*Nateglinide Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Starlix, is not appropriate for the member.

*Prandimet*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred separate products, brand Prandin and generic metformin, are not appropriate for the member.

*Repaglinide Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Prandin, is not appropriate for the member.

*Repaglinide/Metformin Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred separate products, brand Prandin and generic metformin, as well as brand Prandimet, are not appropriate for the member.

*Fortamet ER, Glumetza ER and Metformin SR 24hr Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic metformin ER, is not appropriate for the member.

*Farxiga, Invokamet, Invokana and Jardiance*

- ❖ Approvable for members 18 years of age or older with type 2 diabetes mellitus

*AND*

- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to metformin and either a thiazolidinedione or sulfonylurea

*AND*

- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.

*Glyxambi*

- ❖ Approvable for members 18 years of age or older with type 2 diabetes mellitus

*AND*

- ❖ Member must have experienced an inadequate response to Jentadueto or Kombiglyze after 3 months

*AND*

- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.



*Synjardy*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Jardiance and generic metformin, are not appropriate for the member.

*Xigduo*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Farxiga and generic metformin, are not appropriate for the member.

*Chlorpropamide Generic, Tolazamide Generic and Tolbutamide Generic*

- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to at least 2 preferred sulfonylurea products.

*Actoplus Met XR*

- ❖ Physician must submit a written letter of medical necessity stating the reasons the preferred separate products, generic pioglitazone and generic metformin ER (generic Glucophage XR), are not appropriate for the member.

*Avandia and Avandamet*

- ❖ Approvable for members with type 2 diabetes mellitus

*AND*

- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to pioglitazone.

*Duetact and Pioglitazone/Glimepiride Generic*

- ❖ Physician must submit a written letter of medical necessity stating the reasons the preferred separate products, generic pioglitazone and generic glimepiride, are not appropriate for the member.

*Pioglitazone/Metformin Generic*

- ❖ Physician must submit a written letter of medical necessity stating the reasons the preferred separate products, generic pioglitazone and generic metformin, are not appropriate for the member.

*Byetta*

- ❖ Approvable for members 18 years of age or older with type 2 diabetes mellitus currently on metformin, sulfonylurea and/or thiazolidinedione therapy

*AND*

- ❖ Member must have experienced inadequate response or intolerable side effects to Bydureon

*AND*

- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.

*Bydureon*

- ❖ Approvable for members 18 years of age or older with type 2 diabetes mellitus currently on metformin, sulfonylurea and/or thiazolidinedione therapy

*AND*

- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.



*SymlinPen*

- ❖ Approvable for members 18 years of age or older with type 1 or type 2 diabetes mellitus currently on insulin therapy

*AND*

- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.

*Tanzeum Trulicity and Victoza*

- ❖ Approvable for members 18 years of age or older with type 2 diabetes mellitus currently on metformin, sulfonylurea and/or thiazolidinedione therapy

*AND*

- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or intolerable side effects to Bydureon

*AND*

- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.

*Cycloset*

- ❖ Approvable for members with type 2 diabetes mellitus

*AND*

- ❖ Member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, or history of intolerable side effects to metformin, sulfonylurea, thiazolidinedione and dipeptidyl-peptidase-4 inhibitor.

*AND*

- ❖ Submit documentation of hemoglobin A1c results within the past 6 months.

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

**PREFERRED DRUG LIST:**

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

**PA and APPEAL PROCESS:**

- ❖ For online access to the PA process, please go to <http://dch.georgia.gov/prior-authorization-process-and-criteria> and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- ❖ For online access to the Quantity Level Limits (QLL), please go to <https://www.mmis.georgia.gov/portal>, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.