Updated: 05/2017
PARP Approved: 06/2017

Gateway Health
Prior Authorization Criteria

Jardiance (empagliflozin), Glyxambi (empagliflozin/linagliptin), and Synjardy (empagliflozin/linagliptin)

All requests for Jardiance (empagliflozin), Glyxambi (empagliflozin/linagliptin), and Synjardy (empagliflozin/linagliptin) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Jardiance (empagliflozin), Glyxambi (empagliflozin/linagliptin), and Synjardy (empagliflozin/linagliptin) Prior Authorization Criteria:

- Coverage is provided for a diagnosis of type 2 diabetes mellitus
- Coverage provided for the treatment if the member has tried and failed a minimum of a 4 week trial or had an intolerance to one of the following:
    - Glucophage (metformin)
    - Glucophage XR (metformin ER)
    - Glucovance (metformin/glyburide)
    - Metaglip (metformin/glipizide)
    - Avandamet (metformin/rosiglitazone)
    - Actoplus Met (pioglitazone/metformin)
    - Amaryl (glimepiride)
    - Avandaryl (glimepiride/rosiglitazone)
    - Duetact (glimepiride/pioglitazone)
    - DiaBeta, Glynase, Micronase (glyburide)
    - Glucotrol, Glucotrol XL (glipizide)
    - Januvia (sitagliptin)
    - Janumet/Janumet XR (sitagliptin/metformin)
    - Alogliptin
    - Alogliptin/pioglitazone
    - Alogliptin/metformin

- Approval will be for 12 months

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria, when, in their professional judgment, the requested medication is medically necessary