Clinical Policy: Dapagliflozin/Saxagliptin (Qtern), Dapagliflozin/Saxagliptin/Metformin (Qternmet XR)

Reference Number: CP.CPA.180
Effective Date: 03.01.19
Last Review Date: 02.20
Line of Business: Commercial

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Dapagliflozin/saxagliptin (Qtern®) and dapagliflozin/saxagliptin/metformin (Qternmet® XR) both contain dapagliflozin, a sodium-glucose cotransporter 2 (SGLT2) inhibitor, and saxagliptin, a dipeptidyl peptidase-4 (DPP-4) inhibitor. Qternmet XR also contains metformin, a biguanide.

FDA Approved Indication(s)
Qtern and Qternmet XR are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes.

Dapagliflozin-containing products are also indicated in adult patients with type 2 diabetes mellitus and established cardiovascular disease or multiple cardiovascular risk factors to reduce the risk of hospitalization for heart failure (HF).

Limitation(s) of use:
- Qtern and Qternmet XR are not indicated for the treatment of type 1 diabetes mellitus or diabetic ketoacidosis.
- Qternmet XR initiation is intended only for patients currently taking metformin.

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 health plans affiliated with Centene Corporation® that Qtern and Qternmet XR 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 ≥ 18 years;
3. Failure of Glyxambi® or Trijardy™ XR, unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of at least one other formulary SGLT2 inhibitor or DPP-4 inhibitor, unless all are contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed (a or b):
   a. Qtern: one tablet per day;
   b. Qternmet XR: two tablets per day.

Approval duration: Length of Benefit

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.CPA.09 for commercial.

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 (a or b):
   a. Qtern: one tablet per day;
   b. Qternmet XR: two tablets per day.

Approval duration: Length of Benefit

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.CPA.09 for commercial.

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.CPA.09 for commercial or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
DPP-4: dipeptidyl peptidase-4
FDA: Food and Drug Administration
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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Glyxambi® (empagliflozin/linagliptin)	10 mg/5 mg PO QD	25 mg/5 mg per day
Trijardy™ XR (empagliflozin/linagliptin/ metformin)	One tablet PO QD	25 mg/5 mg/2,000 mg per day
SGLT2 Inhibitors:	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• Invokana® (canagliflozin), • Invokamet®, Invokamet® XR (canagliflozin/metformin), • Farxiga® (dapagliflozin), • Xigduo® XR (dapagliflozin/metformin), • Jardiance® (empagliflozin), • Synjardy®, Synjardy®XR (empagliflozin/metformin), • Steglatro™ (ertugliflozin), • Segluromet™ (ertugliflozin/metformin)		
DPP-4 Inhibitors: • Nesina® (alogliptin), • Kazano® (alogliptin/metformin), • Oseni® (alogliptin/pioglitazone), • Tradjenta® (linagliptin), • Jentadueto®, Jentadueto® XR (linagliptin/metformin), • Onglyza® (saxagliptin), • Kombiglyze® XR (saxagliptin/metformin), • Januvia® (sitagliptin), • Janumet®, Janumet® XR (sitagliptin/metformin)	Varies	Varies

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

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): *both*: moderate to severe renal impairment (eGFR < 45 mL/min/1.73 m^2), end stage renal disease, dialysis, hypersensitivity; *Qternmet XR only*: acute or chronic metabolic acidosis
- Boxed warning(s): none reported for Qtern; lactic acidosis for Qternmet XR

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Dapagliflozin/saxagliptin (Qtern)	One 5 mg/5 mg tablet PO QD	10 mg/5 mg/day
Dapagliflozin/saxagliptin/ metformin (Qternmet XR)	Individualized dose PO QD	10/5/2,000 mg/day

VI. Product Availability

Drug Name	Product Availability
Dapagliflozin/saxagliptin (Qtern)	Tablets: 5 mg/5 mg, 10 mg/5 mg
Dapagliflozin/saxagliptin/ metformin (Qternmet XR)	Tablets: 2.5/2.5/1,000 mg, 5/2.5/1,000 mg, 5/5/1,000 mg, 10/5/1,000 mg

VII. References

1. Qtern Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; June 2019. Available at www.qtern.com. Accessed September 26, 2019.
2. Qternmet XR Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; June 2019. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/210874s000lbl.pdf. Accessed September 26, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2019 Policy created per SDC and prior clinical guidance.	11.06.18	02.19
RT4: no significant changes; added updated FDA approved indication for Qtern; added Qternmet XR; no change to criteria; added 5/5 mg tablets.	07.08.19	
1Q 2020 annual review: no significant changes; added "moderate" renal impairment (eGFR < 45 mL/min/1.73 m^2) to contraindications in Appendix C; added Trijardy XR as a step-through option per SDC; references reviewed and updated.	09.26.19	02.20

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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