

Clinical Policy: Ertugliflozin/Sitagliptin (Steglujan)

Reference Number: CP.CPA.340

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

Ertugliflozin/sitagliptin (Steglujan™) is a combination of ertugliflozin, a sodium-glucose cotransporter 2 (SGLT2) inhibitor, and sitagliptin, a dipeptidyl peptidase-4 (DPP-4) inhibitor.

FDA Approved Indication(s)

Steglujan is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus when treatment with both ertugliflozin and sitagliptin is appropriate.

Limitation(s) of use: Not for the treatment of type 1 diabetes mellitus or diabetic ketoacidosis; Steglujan has 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 health plans affiliated with Centene Corporation® that Steglujan is **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. 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 one tablet 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 one tablet 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: <ul style="list-style-type: none"> • 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) 	Varies	Varies
DPP-4 Inhibitors:	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<ul style="list-style-type: none"> 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) 		

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): severe renal impairment, end stage renal disease, dialysis, hypersensitivity
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Type 2 diabetes mellitus	One 5 mg /100 mg tablet PO QD	15 mg/100 mg per day

VI. Product Availability

Tablets: 5 mg/100 mg, 15 mg/100 mg

VII. References

- Steglujan Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc.; June 2019. Available at www.steglujan.com. Accessed September 26, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created per SDC and prior clinical guidance.	11.06.18	02.19
1Q 2020 annual review: no significant changes; 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.

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