Clinical Policy: Alogliptin (Nesina)
Reference Number: CP.CPA.126
Effective Date: 11.16.16
Last Review Date: 02.19
Line of Business: Commercial

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

Description
Alogliptin (Nesina™) is a dipeptidyl peptidase-4 (DPP-4) inhibitor.

FDA Approved Indication(s)
Nesina is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitation(s) of use: Not for treatment of type 1 diabetes or diabetic ketoacidosis.

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 Nesina 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 ≥ 18 years;
      3. Member meets one of the following (a or b):
         a. Failure of ≥ 3 consecutive months of metformin unless contraindicated or clinically significant adverse effects are experienced;
         b. HbA1c drawn within the past 3 months is ≥ 8.5%, and concurrent use of metformin unless contraindicated or clinically significant adverse effects are experienced;
      4. Dose does not exceed 25 mg per day (1 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 25 mg per day (1 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 policy – CP.CPA.09 for commercial or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   CrCl: creatinine clearance  
   DPP-4: dipeptidyl peptidase-4  
   FDA: Food and Drug Administration  
   HbA1c or A1c: glycated hemoglobin test

   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 and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>metformin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Fortamet®,</td>
<td>Regular-release (Glucophage): 500 mg PO BID or 850 mg PO QD; increase as needed in increments of 500 mg/week or 850 mg every 2 weeks</td>
<td></td>
</tr>
<tr>
<td>Glucomphage®,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucomphage® XR,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glumetza®)</td>
<td>Extended-release:&lt;br&gt;• Fortamet, Glumetza: 1,000 mg PO QD; increase as needed in increments of 500 mg/week &lt;br&gt;• Glucomphage XR: 500 mg PO QD; increase as needed in increments of 500 mg/week</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regular-release: 2,550 mg/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extended-release&lt;br&gt;• Fortamet: 2,500 mg/day&lt;br&gt;• Glucomphage XR, Glumetza: 2,000 mg/day</td>
<td></td>
</tr>
</tbody>
</table>

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): history of a serious hypersensitivity reaction to alogliptin-containing products, such as anaphylaxis, angioedema or severe cutaneous adverse reactions
- Boxed warning(s): none reported

Appendix D: General Information

- Both the American Diabetes Association guideline and the American Association of Clinical Endocrinologist/American College of Endocrinology algorithm recommend metformin as an initial first line agent due to its safety and efficacy profile. Starting with dual therapy (i.e., metformin plus another agent, such as a sulfonylurea, thiazolidinedione, dipeptidyl peptidase-4 inhibitor, sodium-glucose co-transporter inhibitor, GLP-1 receptor agonist, or basal insulin) may be considered for patients with baseline HbA1c ≥ 1.5% above their target per the ADA (≥ 7.5% per the AACE/ACE). According to the ADA, a reasonable HbA1c target for many non-pregnant adults is < 7%.
- There are warning of acute pancreatitis, hepatic failure (fatal), and severe and disabling arthralgia in post marketing reports.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 diabetes mellitus</td>
<td>25 mg PO QD CrCl 30-60: 12.5 mg PO QD CrCl &lt; 30: 6.25 mg PO QD</td>
<td>25 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability

Tablets: 6.25 mg, 12.5 mg, 25 mg

VII. References

CLINICAL POLICY
Alogliptin

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Converted to new template. Minor changes to verbiage and grammar. References updated.</td>
<td>01.13.17</td>
<td>11.17</td>
</tr>
<tr>
<td>1Q18 Annual Review</td>
<td>11.30.17</td>
<td>02.18</td>
</tr>
<tr>
<td>Modified metformin trial requirement to have a mandate a specific duration rather than dose and removed specific definition of failure. Added option for members with A1c ≥ 9% to bypass previous use of metformin for 3 months per ADA guidelines (concurrent metformin use is still required). References reviewed and updated.</td>
<td>10.12.18</td>
<td>02.19</td>
</tr>
<tr>
<td>1Q 2019 annual review: added age ≥ 18 years; clarified metformin trial required to be consecutive months; modified minimum A1c related for concurrent use of metformin from 9% to 8.5% based on 2019 ADA guidelines; references reviewed and updated.</td>
<td>10.12.18</td>
<td>02.19</td>
</tr>
</tbody>
</table>

**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.

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