Clinical Policy: Dapagliflozin/Saxagliptin (Qtern), Dapagliflozin/Saxagliptin/ Metformin (Qternmet XR)
Reference Number: CP.CPA.180
Effective Date: 10.01.18
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
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.

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®, 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. Qtern: one tablet per day;
      b. Qternmet XR: two tablets per day.

Approval duration: Length of Benefit
CLINICAL POLICY
Dapagliflozin/Saxagliptin, Dapagliflozin/Saxagliptin/Metformin

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. 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glyxambi® (empagliflozin/linagliptin)</td>
<td>10 mg/5 mg PO QD</td>
<td>25 mg/5 mg per day</td>
</tr>
<tr>
<td>SGLT2 Inhibitors:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invokana® (canagliflozin),</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>Invokamet®, Invokamet® XR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(canagliflozin/metformin),</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farxiga® (dapagliflozin),</td>
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<td></td>
</tr>
</tbody>
</table>
Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): both: severe renal impairment, 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. Doseage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dapagliflozin/saxagliptin (Qtern)</td>
<td>One 5 mg/5 mg tablet PO QD</td>
<td>10 mg/5 mg/day</td>
</tr>
<tr>
<td>Dapagliflozin/saxagliptin/metformin (Qternmet XR)</td>
<td>Individualized dose PO QD</td>
<td>10/5, 2,000 mg/day</td>
</tr>
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</table>

VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Product Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dapagliflozin/saxagliptin (Qtern)</td>
<td>Tablets: 5 mg/5 mg, 10 mg/5 mg</td>
</tr>
<tr>
<td>Dapagliflozin/saxagliptin/metformin (Qternmet XR)</td>
<td>Tablets: 2.5/2.5/1,000 mg, 5/2.5/1,000 mg, 5/5/1,000 mg, 10/5/1,000 mg</td>
</tr>
</tbody>
</table>

VII. References

2. Qternmet XR Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; May 2019. Available at:
CLINICAL POLICY
Dapagliflozin/Saxagliptin, Dapagliflozin/Saxagliptin/Metformin


Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>1Q 2019 Policy created per SDC and prior clinical guidance.</td>
<td>11.06.18</td>
<td>02.19</td>
</tr>
<tr>
<td>RT4: no significant changes; added updated FDA approved indication for Qtern; added Qternmet XR; no change to criteria; added 5/5 mg tablets.</td>
<td>07.08.19</td>
<td></td>
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</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.

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.

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