Dipeptidyl Peptidase-4 (DPP-4) Inhibitors, DPP-4 Inhibitor/Metformin Combination Drugs

Policy # 00306
Original Effective Date: 05/22/2013
Current Effective Date: 11/09/2020

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc.(collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider Onglyza (saxagliptin), Kombiglyze XR (saxagliptin/metformin extended release), branded Alogliptin, Nesina (alogliptin), branded Alogliptin/Metformin, or Kazano (alogliptin/metformin) to be **eligible for coverage**** when the below patient selection criterion is met:

Patient Selection Criteria

Coverage eligibility will be considered for Onglyza (saxagliptin), Kombiglyze XR (saxagliptin/metformin extended release), branded Alogliptin, Nesina (alogliptin), branded Alogliptin/Metformin, or Kazano (alogliptin/metformin) when the following criterion is met:

- There is clinical evidence or patient history that suggests the use of Januvia (sitagliptin), Janumet (sitagliptin/metformin), Janumet XR (sitagliptin/metformin extended release), Tradjenta (linagliptin), Jentadueto (linagliptin/metformin), or Jentadueto XR (linagliptin/metformin extended release) will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Onglyza (saxagliptin), Kombiglyze XR (saxagliptin/metformin extended release), branded Alogliptin, Nesina (alogliptin), branded Alogliptin/Metformin, or Kazano (alogliptin/metformin) WITHOUT clinical evidence or patient history that suggests the use of Januvia (sitagliptin), Janumet (sitagliptin/metformin),

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Janumet XR (sitagliptin/metformin extended release), Tradjenta (linagliptin), Jentadueto (linagliptin/metformin), or Jentadueto XR (linagliptin/metformin extended release) will be/was ineffective or will/did cause an adverse reaction to the patient to be **not medically necessary**.**

Schematic

Class	Preferred	Non-Preferred
DPP-4 Inhibitors, DPP-4 Inhibitor/Metformin Combination Products	Januvia Janumet Janumet XR Tradjenta Jentadueto Jentadueto XR	Onglyza Kombiglyze XR Branded Alogliptin Nesina Branded Alogliptin/Metformin Kazano

Background/Overview

Dipeptidyl peptidase-4 inhibitors and DPP-4 inhibitor combination drugs are indicated as an adjunct to diet and exercise to improve glycemic control in patients with type 2 diabetes mellitus.

The active ingredients in the non-preferred products have not been studied head to head versus the preferred products and therefore no superiority claims can be made between preferred and non-preferred products.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

All of these products are indicated for the treatment of type 2 diabetes mellitus.

Rationale/Source

Based on a review of the available data and in the absence of any of the caveats mentioned, there is no advantage of using Onglyza (saxagliptin), Kombiglyze XR (saxagliptin/metformin extended release), branded Alogliptin, Nesina (alogliptin), branded Alogliptin/Metformin, or Kazano (alogliptin/metformin) over Januvia (sitagliptin), Janumet (sitagliptin/metformin), Janumet XR (sitagliptin/metformin extended release), Tradjenta (linagliptin), Jentadueto (linagliptin/metformin), or Jentadueto XR (linagliptin/metformin extended release).

References

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4. Nesina tablets [prescribing information]. Deerfield, IL: Takeda Pharmaceuticals America, Inc.; January 2013.
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Policy History

Original Effective Date: 05/22/2013
Current Effective Date: 11/09/2020

05/02/2013	Medical Policy Committee review
05/22/2013	Medical Policy Implementation Committee approval. New policy.
05/01/2014	Medical Policy Committee review
05/21/2014	Medical Policy Implementation Committee approval. No change to coverage.
10/02/2014	Medical Policy Committee review
10/15/2014	Medical Policy Implementation Committee approval. Implemented a PA for non-preferred products to use preferred products, which are Januvia, Janumet, Janumet XR, Onglyza, and Kombiglyze XR.
10/08/2015	Medical Policy Committee review.
10/21/2015	Medical Policy Implementation Committee approval. Considering other preferred products within next few months based on more updated modeling discussions. Will update policy in February 2016 with decisions. Will halt posting until that point.
02/04/2016	Medical Policy Committee review
02/17/2016	Medical Policy Implementation Committee approval. No change to coverage. Will not change preferred products.
06/30/2016	Medical Policy Committee review
07/20/2016	Medical Policy Implementation Committee approval. Added branded Alogliptin, branded Alogliptin/Metformin, Alogliptin/Pioglitazone and Jentadueto XR to the policy.
10/06/2016	Medical Policy Committee review
10/19/2016	Medical Policy Implementation Committee approval. Moving Onglyza and Kombiglyze ER to non-preferred. Moving Tradjenta and Jentadueto/XR to preferred.
10/05/2017	Medical Policy Committee review
10/18/2017	Medical Policy Implementation Committee approval. No change to coverage.
10/04/2018	Medical Policy Committee review
10/17/2018	Medical Policy Implementation Committee approval. Added “metformin” to the title. Removed the step therapy only and step therapy/prior authorization sections. Updated schematic. Updated background info/rationale.

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10/03/2019 Medical Policy Committee review
10/09/2019 Medical Policy Implementation Committee approval. No change to coverage.
10/01/2020 Medical Policy Committee review
10/07/2020 Medical Policy Implementation Committee approval. No change to coverage.
Next Scheduled Review Date: 10/2021

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.