



**GEORGIA MEDICAID FEE-FOR-SERVICE
ANTIDIABETIC AGENTS PA SUMMARY**

Preferred	Non-Preferred
<i>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</i>	
Januvia (sitagliptin) Janumet (sitagliptin/metformin) Janumet XR (sitagliptin/metformin ER) Jentadueto (linagliptin/metformin) Jentadueto XR (linagliptin/metformin ER) Tradjenta (linagliptin)	Alogliptin generic Alogliptin/metformin generic Alogliptin/pioglitazone
<i>Meglitinides</i>	
Nateglinide generic Repaglinide generic	n/a
<i>Metformin Products</i>	
Metformin generic Metformin ER (generic Glucophage XR, Glumetza)	Metformin ER osmotic (generic Fortamet ER)
<i>Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors</i>	
Farxiga (dapagliflozin) Jardiance (empagliflozin) Xigduo XR (dapagliflozin/metformin ER)	Glyxambi (empagliflozin/linagliptin) Inpefa (sotagliflozin) Invokamet XR (canagliflozin/metformin ER) Invokamet (canagliflozin/metformin) Invokana (canagliflozin) Segluromet (ertugliflozin/metformin) Steglatro (ertugliflozin) Steglujan (ertugliflozin/sitagliptin) Synjardy (empagliflozin/metformin) Synjardy XR (empagliflozin/metformin ER) Trijardy XR (empagliflozin/linagliptin/metformin ER)
<i>Sulfonylureas</i>	
Glimepiride generic Glipizide generic Glyburide generic	n/a
<i>Thiazolidinediones (TZD)</i>	
Pioglitazone generic	Pioglitazone/glimepiride generic Pioglitazone/metformin generic
<i>Miscellaneous Antidiabetic Agents</i>	
Exenatide generic SymlinPen (pramlintide)* Victoza (liraglutide)	Cycloset (bromocriptine) Mounjaro (tirzepatide) Ozempic (semaglutide injection) Rybelsus (semaglutide tablets) Soliqua (insulin glargine/lixisenatide) Trulicity (dulaglutide) Xultophy (insulin degludec/liraglutide)
<i>Alpha-Glucosidase Inhibitors</i>	
Acarbose generic	Miglitol generic

*Preferred but requires PA; ER/XR=extended-release; IR=immediate-release



LENGTH OF AUTHORIZATION: Varies

NOTES:

- SymlinPen is preferred but requires prior authorization (PA).

PA CRITERIA:

Alogliptin Generic, Alogliptin/Metformin Generic and Alogliptin/Pioglitazone Generic

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 preferred DPP-4 inhibitors.

Metformin ER Osmotic Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, metformin ER (generic Glucophage XR and generic Glumetza), are not appropriate for the member.

Glyxambi

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, Jardiance and Tradjenta, are not appropriate for the member.

Inpefa

- ❖ Approvable for members 18 years of age or older with a diagnosis of heart failure or type 2 diabetes mellitus, chronic kidney disease (CKD) and other cardiovascular (CV) risk who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to the preferred SGLT2 inhibitors Farxiga and Jardiance.

Invokamet and Invokamet XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Invokamet with generic metformin or generic metformin ER (generic Glucophage XR and generic Glumetza), are not appropriate for the member.

Invokana

- ❖ Approvable for members 10 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with metformin, thiazolidinedione or sulfonylurea, as well as Farxiga or Xigduo XR and Jardiance.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher, have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease or peripheral artery disease) and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Farxiga or Xigduo XR and Jardiance.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher, have diabetic nephropathy with albuminuria and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Farxiga or Xigduo XR and Jardiance.



Steglatro

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with metformin, thiazolidinedione or sulfonylurea, as well as Farxiga or Xigduo XR and Jardiance.

Segluromet

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Steglatro and generic metformin, are not appropriate for the member.

Steglujan

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Steglatro and Januvia, are not appropriate for the member.

Synjardy

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, Jardiance, and generic metformin, are not appropriate for the member.

Synjardy XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, Jardiance, and metformin ER (generic Glucophage XR, Glumetza), are not appropriate for the member.

Trijardy XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, Jardiance, Tradjenta and metformin ER (generic Glucophage XR, Glumetza), are not appropriate for the member.

Pioglitazone/Glimepiride Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, generic pioglitazone, and generic glimepiride, are not appropriate for the member.

Pioglitazone/Metformin Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, generic pioglitazone, and generic metformin, are not appropriate for the member.

Cycloset

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with metformin as well as 3 of the following: sulfonylurea, thiazolidinedione, DPP-4 inhibitor and SGLT2 inhibitor.

Mounjaro



- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, SGLT2 inhibitor, sulfonylurea or thiazolidinedione therapy who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with exenatide, Victoza and Ozempic.

Ozempic

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, SGLT2 inhibitor, sulfonylurea or thiazolidinedione therapy and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with exenatide and Victoza.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus with chronic kidney disease (CKD) whose HbA1c level is 7% or higher and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with metformin and SGLT2 inhibitor (Farxiga, Xigduo XR, Jardiance).
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher, have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease or peripheral artery disease) and have experienced an inadequate response, allergy contraindication, drug-drug interaction or intolerable side effect with Victoza.

Rybelsus

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, SGLT2 inhibitor, sulfonylurea or thiazolidinedione therapy and have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Farxiga, Xigduo XR or Jardiance and exenatide or Victoza.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher, have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease or peripheral artery disease) and have experienced an inadequate response, allergy contraindication, drug-drug interaction or intolerable side effect with Victoza.

Soliqua

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin and have failed to achieve glycemic targets with combination therapy of Lantus and Victoza as well as combination therapy of Lantus and exenatide or have allergies, contraindications, drug-drug interactions or intolerable side effects to metformin, exenatide and Victoza.

Trulicity

- ❖ Approvable for members 10 to 17 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with Victoza.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, SGLT2 inhibitor, sulfonylurea



or thiazolidinedione therapy and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with exenatide, Victoza and Ozempic.

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c is 7% or higher, have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease, or peripheral artery disease) or multiple cardiovascular risk factors and have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable with Victoza and Ozempic.

Xultophy

- ❖ Approvable for members who have been stabilized on combination therapy with the individual agents, Tresiba and Victoza.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin and have failed to achieve glycemic targets with combination therapy of Lantus and Victoza as well as combination therapy of Levemir and Victoza, or have allergies, contraindications, drug-drug interactions or intolerable side effects to metformin, Lantus and Levemir.

Miglitol

- ❖ Approvable for members who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 preferred oral antidiabetic agents, one of which must be acarbose.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to <http://dch.georgia.gov/prior-authorization-process-and-criteria> and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL List.