GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ANTIDIABETIC AGENTS PA SUMMARY

Preferred	Non-Preferred
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	
Januvia (sitagliptin) Janumet (sitagliptin/metformin) Janumet XR (sitagliptin/metformin ER) Jentadueto (linagliptin/metformin) Jentadueto XR (linagliptin/metformin ER) Kombiglyze (saxagliptin/metformin) Onglyza (saxagliptin) Tradjenta (linagliptin)	Alogliptin generic Alogliptin/metformin generic Alogliptin/pioglitazone
Meglitinides	
Nateglinide generic Repaglinide generic	n/a
Metformin Products	
Metformin generic Metformin ER (generic Glucophage XR, Glumetza) Riomet (metformin IR oral solution)	Fortamet (metformin ER osmotic) Metformin ER osmotic (generic Fortamet ER) Riomet ER (metformin ER oral suspension)
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	
Farxiga (dapagliflozin) Jardiance (empagliflozin) Xigduo XR (dapagliflozin/metformin ER)	Glyxambi (empagliflozin/linagliptin) Inpefa (sotagliflozin) Invokamet XR (canagliflozin/metformin ER) Invokamet (canagliflozin/metformin) Invokana (canagliflozin) Qtern (dapagliflozin/saxagliptin) Segluromet (ertugliflozin/metformin) Steglatro (ertugliflozin) Steglujan (ertugliflozin/sitagliptin) Synjardy (empagliflozin/metformin) Synjardy XR (empagliflozin/metformin ER) Trijardy XR (empagliflozin/linagliptin/metformin ER)
Sulfonylureas	
Glimepiride generic Glipizide generic Glyburide generic	Tolbutamide generic
Thiazolidinediones (TZD)	
Pioglitazone generic	Pioglitazone/glimepiride generic Pioglitazone/metformin generic
Miscellaneous Antidiabetic Agents	
Byetta (exenatide) SymlinPen (pramlintide)* Victoza (liraglutide)	Adlyxin (lixisenatide) Bydureon BCise (exenatide ER) Cycloset (bromocriptine) Mounjaro (tirzepatide) Ozempic (semaglutide injection) Rybelsus (semaglutide tablets) Soliqua (insulin glargine/lixisenatide) Trulicity (dulaglutide)

Revised 09/17/2024

	Xultophy (insulin degludec/liraglutide)
Alpha-Glucosidase Inhibitors	
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 who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 preferred DPP-4 inhibitors.

Fortamet and 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.

Riomet ER Oral Suspension

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Riomet IR Oral Solution, is 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 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 and 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 failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with metformin, thiazolidinedione, or sulfonylurea, as well asFarxiga and Jardiance.

Qtern

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

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.

Tolbutamide Generic

- Approvable for members who have experienced inadequate response, allergies, contraindications, drug-drug interactions, or intolerable side effects to at least 2 preferred sulfonylurea products.

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.

Adlyxin

- 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, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions, or intolerable side effects with Byetta and Victoza.

Bydureon BCise

- For members 10 to 17 years of age with a diagnosis of type 2 diabetes mellitus, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Victoza, is not appropriate for the member.
- For members 18 years of age or older with a diagnosis of type 2 diabetes mellitus, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Byetta and Victoza, 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 failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with metformin, sulfonylurea, thiazolidinedione, and dipeptidyl-peptidase-4 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, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions, or intolerable side effects with Byetta and Victoza.

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, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions, or intolerable side effects with Byetta and Victoza.
- Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus who have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease, or peripheral artery disease) who 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, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions, or intolerable side effects with Farxiga or Jardiance and Byetta or Victoza.

Soliqua

- Approvable for members who have been stabilized on combination therapy with the individual agents, Lantus and Adlyxin.
- 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 Byetta, or have allergies, contraindications, drug-drug interactions, or intolerable side effects to metformin, Byetta and Victoza.

SymlinPen

- Approvable for members 18 years of age or older with a diagnosis of type 1 or type 2 diabetes mellitus whose HbA1c level is 7% to 9% currently on insulin therapy.

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 failed to achieve HbA1c goal or has an 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, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions, or intolerable side effects with Byetta, Victoza and Ozempic.
- Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus who have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease, or peripheral artery disease) and have failed therapy with or have 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.