Criteria Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE

Canagliflozin/ Metformin XR (Invokamet XR)

Non-formulary Canagliflozin/ Metformin XR (Invokamet XR) will be covered on the prescription drug benefit when the following criteria are met:

1. Diagnosis of Diabetes Mellitus type 2 (DM 2) on Problem List
   -AND-
2. Intolerance to preferred SGLT-2 inhibitor/biguanide combination empagliflozin/metformin (Synjardy) which is also CBC
   -AND-
3. Recent HbA1c (within 2 months prior to prescribing) between 7 and 9
   -AND-
4. On maximum dose for at least 3 months of 1 of the following 2 drug combinations:
   -Metformin (2000-2550 mg/day) and sulfonylurea (glipizide 20-40 mg/day or equivalent)
   -Metformin (2000-2550 mg/day) and pioglitazone (45 mg/day)
   -AND-
5. Prior inadequate response to insulin despite optimal dosing (total daily insulin dose of 1.5 units per kilogram)
   -OR-
6. Use in patients with type 2 diabetes mellitus that experience recurrent nocturnal hypoglycemia with basal insulin defined as: 3 or more episodes of nocturnal CBG less than 70 over the preceding 30 days that persists despite insulin [NPH THEN glargine] dose reduction
   -OR-
7. Use in patients with type 2 diabetes mellitus on basal insulin that experience any episode of severe hypoglycemia defined as: hypoglycemia resulting in seizures, loss of consciousness, episode necessitating assistance from someone else, EMT, use of glucagon
   - OR -
8. Dose change only: Patient previously met criteria and is already taking the drug

Conversion criteria:
Discontinue Invokamet XR if A1c goal is not met within 6 months of starting it