Criteria Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE
Alogliptin/metformin (Kazano)

Non-formulary **Alogliptin/metformin (Kazano)** 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 DPP-4 inhibitor/biguanide combination linagliptin/metformin (Jentadueto) 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 (low blood sugar at night) with basal insulin defined as: 3 or more episodes of nocturnal CBG (capillary blood glucose at night) 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 (emergency medical technician), and/or use of glucagon (medication used to raise the concentration of glucose in the blood)  
   -OR-  
8. Dose change only: Patient previously met criteria and is already taking the drug

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