Criteria Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE

Ertugliflozin/ Sitagliptin (Steglujan)

Non-formulary Ertugliflozin/ Sitagliptin (Steglujan) 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/DPP4 inhibitor combination empagliflozin/ linagliptin (Glyxambi) 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 Steglujan if A1c goal is not met within 6 months of starting it