Novel Medications
for Diabetic Kidney Disease

SGLT2i's & GLP-1 RA's

MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

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MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

GLP-1 Receptor Agonists

Medication	Dosing	Initial Dose	Titration	Needles Included	Renal Dosing		
Exenatide (Byetta)	SQ 2x daily	Multi-dose pen (5-10 mcg BID AC)	Every 4 weeks	**NO** RX needed	✓ **CrCl > 50:** No adjustment needed	! **CrCl 30-50:** Adjustment needed	✗ **CrCl < 30:** Do not use
Dulaglutide (Trulicity)	SQ weekly	Single-dose pen (0.75-4.5mg QW)	Every 4 weeks	**YES** auto-injector with retracting needle	✓ No adjustment needed		
Exenatide (BCise)	SQ weekly	BCise single-dose auto-injector (2mg)	None	**YES** auto-injector with retracting needle	✓ **CrCl > 50:** No adjustment needed	! **CrCl 30-50:** Adjustment needed	✗ **CrCl < 30:** Do not use
Liraglutide (Victoza)	SQ daily	Multi-dose pen (0.6-1.8 mg QD)	Every week	**NO** RX needed (31G or 32G pen needle)	✓ No adjustment needed		
Lixisenatide (Adlyxin)	SQ daily	Multi-dose pen (10 or 20 mcg QD AC)	Every 2 weeks	**NO** RX needed	✓ **CrCl ≥ 30:** No adjustment needed	! **CrCl 15-29:** Adjustment needed	✗ **CrCl < 15:** Do not use
Semaglutide (Ozempic)	SQ weekly	Multi-dose pen (0.25/0.5 and 1mg QW)	Every 4 weeks	**YES** included with pen	✓ No adjustment needed		
Semaglutide (Rybelsus)	PO daily	3/7/14mg tab QD AC	Every 4 weeks	**N/A**	✓ No adjustment needed		

GLP-1 Receptor Agonists
Precautions (Numbered in order from high to low frequency)

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

1 Gastrointestinal Symptoms
(nausea, vomiting, diarrhea>constipation, abdominal pain, etc.)

Dose-dependent

May be worse in patients with gastroparesis or GERD

Often improves with time

2 Hypoglycemia

Typically only occurs when used with insulin or sulfonylurea therapy

In patients already achieving target HbA1c, preemptively lower insulin / sulfonylurea dose

3 Injection Site Reactions

Typically mild

4 Acute kidney injury

Attributed to pre-renal factors from GI side effects in patients with AKI risk factors

Rare instances of allergic interstitial nephritis have also been reported

5 Pancreatitis

Inconsistent finding in clinical studies

Consider avoiding in patients with risk factors for OR history of pancreatitis

Contraindications

Contraindicated in patients with:
- Personal or family hx of medullary thyroid cancer or multiple endocrine neoplasia type 2 (based on findings from animal studies, not observed in clinical trials)
- Pregnancy or breastfeeding
- Allergy to GLP-1 RAs

Severity of Precaution: Low · Moderate · **Severe** [Severe side effects are rare]

SGLT2 Inhibitors
Precautions (Numbered in order from high to low frequency)

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Severity of Precaution:

- Low
- Moderate
- Severe

[1]canagliflozin
[2]dapagliflozin
TDD = total daily dose;
SU – sulfonylurea;
[a]Heyward, 2020
[b]Dicembrini, 2019
[c]Qiu, 2021

1 Genital Mycotic Infections

Avoid if high risk, severe hx
- Treat severe hyperglycemia first, then start SGLT2
- Treat if mild, stop if recurrent

2 Low Blood Sugar

If HbA1c < 8.5%
- reduce TDD insulin 20%
- reduce SU 50% or hold

If HbA1c > 8.5%
adjust as needed

3 Low Blood Pressure

Consider holding diuretic and other anti-HTN med **if BP well controlled or age > 65**

4 Risk of Dehydration

Treat severe hyperglycemia prior to starting SGLT2i
Drink water!

5 Diabetic Ketoacidosis

Euglycemic Ketoacidosis

Avoid use with ketogenic (<50g carbs/day) diet
Hold for sick days, dehydration or with fasting such as pre- procedures (i.e. colonoscopy or surgery.

6 Low Renal Function
eGFR<45

Closely monitor GFR

Early fall in eGFR is expected (less than 10%)
Hold SGLT2i on sick days
Hold SGLT2i 24-48H preop

7 Necrotizing Fasciitis of Perineum

Anticipatory guidance
Monitor closely

* **Bladder Cancer[2,b]**
Screen for high risk or history of bladder cancer

* **Bone fracture[1,c]**
Screen for fall risk.
Manage low blood pressure

* **Lower Limb / Toe Amputation[1,a,c]**
Avoid in prior amputation, severe PVD or high risk.
Monitor foot health

* These risks have been reported in some clinical trials. Recent meta-analyses show no statistically significant risk. Use caution.

What's New in this Guide

Last updated 14 March 2023
v2023.1.2

Change Log

Payer	Drug/Device	Change
United	**Jardiance** (Empagliflozin)	Removed metformin step therapy requirement. As of Oct 10, 2022.
BCBSM Medicare Advantage	**Jardiance** (Empagliflozin)	FIXED: Jardiance is Preferred (Tier 3 - lowest branded copay). As of Oct 1, 2022.
BCBSM	**Mounjaro** (tirzepatide)	Changed from "No Info" to Non Preferred, PA="For the treatment of Type 2 Diabetes or trial of one generic or preferred medication for the treatment of Type 2 Diabetes"
Priority Health Optimized	**Mounjaro** (tirzepatide)	Changed from "No Info" to Preferred Tier 2 (brand) with prior authorization. Please review the plan's PA criteria, as it is more stringent than Priority Health Traditional commercial plan.
HAP	**Mounjaro** (tirzepatide)	Mounjaro is now covered
United	**Mounjaro** (tirzepatide)	Mounjaro is now covered, with PA/ST trial of, or CI metformin
United	**Farxiga** (dapagliflozin) **Invokana** (canagliflozin)	Changed from "Non Preferred with ST " to "May be excluded from coverage or subject to PA in CT, NJ and NY."
All	**Adlyxin** (Lixisenatide)	Adlyxin is no longer covered in the United States
Aetna	**Phentermine**	Phentermine is no longer covered
Express Scripts	**Phentermine**	Phentermine is no longer covered
HAP	**Qsymia** (Phentermine - Topiramate)	Changed from "Not Covered" to Not Preferred ($$$$) with PA

PRIVATE & PBM Coverage for GLP-1 RA & GIP

USE CO-PAY COUPON

RECOMMENDED

	TRULICITY Dulaglutide *Injectable - Weekly*	OZEMPIC Semaglutide *Injectable - Weekly*	RYBELSUS Semaglutide *Oral - Daily*	VICTOZA Liraglutide *Injectable -Daily*	MOUNJARO Tirzepatide *Injectable - Weekly*	BYDUREON BCISE Exenatide *Injectable - Weekly*
AETNA	Preferred PA	Preferred PA	Preferred PA	Preferred PA	No Info	Not Covered
BCBSM	Preferred	Preferred	Preferred	Not Covered	PA **Non Preferred** T2D OR trial of generic or preferred med for T2D	Not Covered
EXPRESS SCRIPTS National Preferred	Preferred	Preferred	Preferred	Not Covered	Preferred	Preferred
HAP	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Not Covered
PRIORITY	Preferred	Preferred Must have T2D diagnosis code	Not Covered	Preferred	Preferred PA If T2D ICD-9 code is not on file	Non Preferred ST Must first try Trulicity, Bydureon, or Byetta
PRIORITY (OPTIMIZED)	Preferred PA See PA criteria below	$$$$$$ PA ST Criteria as of Feb '22: michmed.org/3A2Av	Not Covered	$$$$$$ PA ST Criteria as of Feb '22: michmed.org/3A2Av	Preferred PA See PA criteria below	$$$$$$ Specialty PA
UNITED	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST

BYDUREON BCISE - Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

PA **Prior Auth**

ST **Step Therapy**

See last page of guide for links to available prior auth and step therapy documentation

Priority Optimized--Trulicity and Mounjaro are PREFERRED. For others, must meet criteria:
1. Trial and failure, or intolerance to at least 2 generic oral antidiabetic agents used in combination OR insulin after 3 continuous months of receiving maximal daily doses, in conjunction with diet and exercise, and not achieving adequate glycemic control (must be within the last 6 months).
2. Hemoglobin A1c less than or equal to 9%, but not less than 7%

PRIVATE & PBM
Coverage for SGLT2i

Use COPAY COUPON PROGRAMS

Recommended

	JARDIANCE Empagliflozin *Oral - Daily*	FARXIGA Dapagliflozin *Oral - Daily*	INVOKANA Canagliflozin *Oral - Daily*	STEGLATRO Ertugliflozin *Oral - Daily*
AETNA	Preferred ST	Preferred ST	Not Covered	Not Covered
BCBSM	Preferred	Preferred	Not Covered	Not Covered
EXPRESS SCRIPTS National Preferred	Preferred	Preferred	Not Covered	Preferred
HAP	Preferred	Preferred	Not Covered	Not Covered
PRIORITY	Preferred	Preferred	Non Preferred ST Must first try Farxiga OR Jardiance	Non Preferred ST Must first try Farxiga OR Jardiance
PRIORITY (OPTIMIZED)	Preferred	Preferred	Non Preferred ST Must first try Farxiga OR Jardiance	Non Preferred ST Must first try Farxiga OR Jardiance
UNITED	Preferred	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY michmed.org/Yk9Yb	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY michmed.org/Yk9Yb	Not Covered

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

ST **Step Therapy**

See last page of guide for links to available prior auth and step therapy documentation

Information based on general formularies, unless otherwise noted (i.e. Priority Optimized plan, ExpressScripts PBM) and may not reflect employer-group specific policies and plans with pharmacy carve outs.

MEDICARE ADVANTAGE
Coverage for GLP-1 RA & GIP

Use PATIENT ASSISTANCE PROGRAMS

Recommended

	TRULICITY Dulaglutide *Injectable - Weekly*	OZEMPIC Semaglutide *Injectable - Weekly*	RYBELSUS Semaglutide *Oral - Daily*	VICTOZA Liraglutide *Injectable -Daily*	MOUNJARO Tirzepatide *Injectable - Weekly*	BYDUREON BCISE Exenatide *Injectable - Weekly*
AETNA MA	Preferred	Preferred	Preferred	Preferred	No Info	Preferred
BCBSM/BCN MA	Preferred	Preferred	Preferred	Preferred	No Info	Preferred
HAP MA	Preferred ST	Preferred ST	Preferred ST	Preferred ST	No Info	Not Covered
HUMANA MA	Preferred	Preferred	Preferred	Preferred	Preferred	$$$$$$ Not Preferred
PRIORITY MA	Preferred	$$$$$$ Non Preferred ST	Not Covered	$$$$$$ Non Preferred ST	Preferred	Preferred
UNITED EGWP	Preferred	Preferred	Preferred	Preferred	No Info	Preferred
WELLCARE MA	Preferred	Preferred	Preferred	Preferred	No Info	Preferred

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

Note on BCBSM/BCN MA: Individually purchased Prescription Blue PDP does not cover Trulicity. All other BCBS MA plans do, including Group Prescription Blue PDP.

ST **Step Therapy**

See last page of guide for links to available prior auth and step therapy documentation

MEDICARE ADVANTAGE
Coverage for SGLT2i

Use PATIENT ASSISTANCE PROGRAMS

Recommended

	JARDIANCE Empagliflozin *Oral - Daily*	FARXIGA Dapagliflozin *Oral - Daily*	INVOKANA Canagliflozin *Oral - Daily*	STEGLATRO Ertugliflozin *Oral - Daily*
AETNA MA	Preferred	Preferred	Not Covered	Not Covered
BCBSM/BCN MA	Preferred	Preferred		Not Covered
HAP MA	Preferred	Preferred	Not Covered	Not Covered
HUMANA MA	Preferred	$$$$$$ Non-Preferred	Preferred	Not Covered
PRIORITY MA	Preferred	Preferred	Non Preferred ST Must first try Farxiga, Xigduo, Jardiance or Synjardy	Non Preferred ST Must first try Farxiga, Xigduo, Jardiance or Synjardy
UNITED EGWP	Preferred	Preferred	Not Covered	Not Covered
WELLCARE MA	Preferred	Preferred	$$$$$$ Non Preferred	Not Covered

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

ST **Step Therapy**

See last page of guide for links to available prior auth and step therapy documentation

MEDICAID COVERAGE for GLP-1 RA & GIP

Recommended

	TRULICITY Dulaglutide *Injectable - Weekly*	OZEMPIC Semaglutide *Injectable - Weekly*	RYBELSUS Semaglutide *Oral - Daily*	VICTOZA Liraglutide *Injectable -Daily*	MOUNJARO Tirzepatide *Injectable - Weekly*	BYDUREON BCISE Exenatide *Injectable - 2X a day / Weekly*
MEDICAID State	Preferred	$$$$$$ Non-Preferred PA michmed.org/2VP94	$$$$$$ Non-Preferred PA michmed.org/2VP94	Preferred	Not Covered	$$$$$$ Non Preferred PA
AETNA **BCBSM** **HAP** **MCCLAREN** **MERIDIAN** **MOLINA** **PRIORITY** **UNITED** Managed	Preferred	Not Covered *Except Aetna* *Non-preferred* *PA*	Not Covered *Except Aetna* *Non-preferred* *PA*	Preferred	No Info *Except Aetna, BCBSM, United* *Not Covered*	Not Covered *(Byetta)* Not Covered *except for Aetna* *Non Preferred* *(Bydureon BCise)*

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

MEDICAID COVERAGE for SGLT2i

Recommended

	JARDIANCE Empagliflozin *Oral - Daily*	FARXIGA Dapagliflozin *Oral - Daily*	INVOKANA Canagliflozin *Oral - Daily*	STEGLATRO Ertugliflozin *Oral - Daily*
MEDICAID State	Preferred	Preferred	Preferred	$$$$$$ Non-Preferred PA
AETNA **BCBSM** **HAP** **MCCLAREN** **MERIDIAN** **MOLINA** **PRIORITY** **UNITED** Managed	Preferred	Preferred *Except HAP* *Not Covered - PA*	Preferred	Not Covered *Except Aetna* *Non-preferred* *PA*

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

PRIVATE & PBM COVERAGE for Anti-Obesity Meds

	SAXENDA Liraglutide *Injectable - Daily*	WEGOVY Semaglutide *Injectable - Weekly*	PHENTERMINE Generic - High Dose *Oral - Daily w/ Meals*	LOMAIRA Phentermine 8 Low Dose *Oral - Daily w/ Meals*	QSYMIA Phentermine - Topiramate *Oral - Daily*	CONTRAVE Naltrexone HCl - Bupropion HC *Oral - 2x Day*
AETNA	Preferred PA	Preferred PA	Not Covered	Not Covered	Preferred	Not Covered
BCBSM	$$$$$$ Non-Preferred PA	Preferred PA	Preferred	$$$$$$ Non-Preferred	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA
EXPRESS SCRIPTS National Preferred	$$$$$$ Non-Preferred PA	Preferred PA	Not Covered	Preferred	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA
HAP	Not Covered	Not Covered	Preferred	Not Covered	$$$$$$ Non-Preferred PA	Not Covered
PRIORITY	Not Covered	Not Covered	Preferred	$$$$$$ Non-Preferred ST Must try generic first	$$$$$$ Non-Preferred** ST Must try generic first	$$$$$$ Non-Preferred ST Must try generic first
PRIORITY (OPTIMIZED)	Not Covered	Not Covered	Preferred	Not Covered	$$$$$$ Non-Preferred ST Must try generic first	$$$$$$ Non-Preferred ST Must try generic first
UNITED	Not Covered	Not Covered	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY	Not Covered	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY

PA **Prior Auth**

ST **Step Therapy**

See last page of guide for links to available prior auth and step therapy documentation

Disclaimer: Information based on general formularies, unless otherwise noted and may not reflect employer-group specific policies and plans with pharmacy carve outs.
**Priority coverage for Qsymia determined by: "Employers plan rider determines weight loss coverage"

MEDICARE ADVANTAGE
Coverage for Anti-Obesity Meds

No plans (at this time) offer coverage for: phentermine (any formulation), Qsymia, Contrave, Saxenda, or Wegovy

MEDICAID
Coverage for Anti-Obesity Meds

	PHENTERMINE Generic - High Dose *Oral - Daily w/ Meals*	LOMAIRA Phentermine 8 Low Dose *Oral - Daily w/ Meals*	QSYMIA Phentermine - Topiramate *Oral - Daily*	CONTRAVE Naltrexone HCl - Bupropion HC *Oral - 2x Day*	SAXENDA Liraglutide *Injectable - Daily*	WEGOVY Semaglutide *Injectable - Weekly*
MEDICAID State	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*
AETNA **BCBSM** **HAP** **MCCLAREN** **MERIDIAN** **MOLINA** **PRIORITY** **UNITED** Managed	Preferred *Except Priority Not Covered* PA *Age Criteria*	Preferred *Except McClaren Not Covered* PA	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*

PA
Prior Auth

ST
Step Therapy

See last page of guide for links to available prior auth and step therapy documentation

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE

	COVERAGE		CRITERIA - DOCUMENT IN CHART NOTE				
	PHARMACY	MEDICAL/DME	Needs T2D Diagnosis	Insulin	Hypoglycemic events	Seen for diabetes management in past 6 months	Additional criteria and notes
Medicare & Medicare Advantage	**NONE**	Preferred Brand(s) **Abbott Dexcom** Policy Link: michmed.org/dJ8z3	**Required**	**Required** *Needs 3+ daily insulin injections or pump. Requires frequent adjustment to the insulin treatment regimen based on glucose results (either finger stick or CGM readings)*	**Not Required**	**YES** In-person appointment 6 months prior to ordering CGM AND 6 months after	Try ePrescribing platform Parachute Health for Medicare DME ordering Device must have standalone reader (not just smartphone app) to qualify for DME
Medicaid	**NONE**	PA Determined on a case by case basis	**UNKNOWN**	**UNKNOWN**	**UNKNOWN**	**UNKNOWN**	
Blue Cross Complete (BCBSM managed Medicaid)	Preferred Brand(s) **Abbott Dexcom** Policy Link: michmed.org/PJGPA		**Required**	**Required** *OR* Treatment with an antihyperglycemic drug without insulin ***AND one criteria on right***	**Requied,** ***ONLY IF not on insulin*** Frequent hypoglycemia, hypoglycemia unawareness, or concerns of nocturnal hypoglycemia ***OR ONE of the criteria listed (see right)***	**Not Required**	***IF NOT on insulin, NOT experiencing hypoglycemia,*** must meet one (1): a.) Gaining weight (more than 5 pounds of weight gain in the last 12 months) b.) HbA1C ≥ 7% c.) Need for medication changes or titration d.) Initiation of a lower carbohydrate diet e.) Patient is unable or reluctant to test their blood glucose via traditional glucometer f.) Patients taking two or more medications to manage their diabetes. g.) Patient works with a care team member to improve diet and exercise choices

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE

	COVERAGE		CRITERIA - DOCUMENT IN CHART NOTE				
	PHARMACY	MEDICAL/DME	Needs T2D Diagnosis	Insulin	Hypoglycemic events	Seen for diabetes management in past 6 months	Additional criteria and notes
Aetna	**NONE**	Preferred Brand(s) **Dexcom** Policy Link: https://michmed.org/3xAqb	**Required**	**Required** *Needs 3+ daily insulin injections or pump*	**Required** Including hypoglycemic unawareness OR not meeting glycemic targets	**Not Required** But may be required for continued use (see right)	***For continued use, must document EITHER*** a.) Experiencing improved glycemic control or decreased hypoglycemia episodes while using a CGM b.) Are being assessed every six months by the prescriber for adherence to their CGM regimen and diabetes treatment plan.
BCBSM *Consult Individual Plans*	Preferred Brand(s) **Dexcom** *receiver & transmitter at $0 cost share* **Abbott** ***Have a pharmacy carveout? Refer to your carvoeout plan company's coverage criteria.***	**See Criteria (right)**	**Required**	**Required** *Needs 3+ daily insulin injections or pump and not meeting glycemic targets*	**Required** *Have recurrent, unexplained, severe hypoglycemia (generally blood glucose levels <50 mg/dL) or impaired awareness of hypoglycemia that puts the patient or others at risk*	**UNKNOWN**	**For pregnant patients:** *Have poorly controlled insulin requiring diabetes, includes unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis.*
HAP *Commercial and Medicare Advantage plans*	Preferred Brand(s) **Dexcom Abbott Freestyle Libre** *$0 copay if through Pharmacy Advantage or patient's pharmacy*	**NONE**	**Required**	**Required** *Must be treated with insulin OR Treated with 3+ non-insulin products AND has uncontrolled HgBA1c*	**Not Required**	**Not Required**	**Use PREFERRED VENDOR** *Pharmacy Advantage* *(800) 456-2112,* *M-F, 8 a.m. to 6 p.m.* *https://www.pharmacyadvantagerx.com/index.cfm*
McLaren	Preferred Brand(s) **Dexcom** PA		**UNKNOWN**	**UNKNOWN**	**UNKNOWN**	**UNKNOWN**	

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE

	COVERAGE		CRITERIA - DOCUMENT IN CHART NOTE				
	PHARMACY	MEDICAL/DME	Needs T2D Diagnosis	Insulin	Hypoglycemic events	Seen for diabetes management in past 6 months	Additional criteria and notes
Molina	Preferred Brand(s) **Abbott Dexcom**	Preferred Brand(s) **Abbott Dexcom** Policy Link: https://michmed.org/gRWVY **PA**	**Required** *OR Documentation member is pregnant receiving insulin therapy*	**1.) ONE of the following (a-g) PLUS Additional criteria (2-3)** *a.) Compliant with 3x injections or pump* *b.) HbA1c above 7% and 4x daily readings*	*c.) Persistent, recurrent unexplained severe hypoglycemic events* *d.) Hypoglycemia unawareness* *e.) Episodes of ketoacidosis* *f.) Hospitalizations for uncontrolled glucose levels* *g.) Frequent nocturnal hypoglycemia despite appropriate modifications in insulin therapy*	**Not Required**	2.) Prescriber attests to scheduled or historical (last 12 mon) completion of training and support for CGM **AND** member/caregiver has ability to perform self-monitoring of blood glucose in order to calibrate the monitor if needed and/or verify readings if discordant from their symptoms. 3.) Prescriber attests member/caregiver has been counseled on potential drugs/substances that can falsely raise or lower CGM glucose levels such as APAP, ASA, vitamin C etc.
Priority *Traditional & Optimized*	Preferred Brand(s) **Dexcom Abbott**	**UNKNOWN**	**Required**	**Not Required**	**Not Required**	**Not Required**	
United	***MCT2D members*** who are UHC in-network providers **CAN BYPASS CRITERIA.** Only T2D diagnosis required Preferred Brand(s) **Abbott Dexcom** *(Tier 3 - Highest Cost)* **PA**	Preferred Brand(s) **Abbott Dexcom** Policy Link: https://michmed.org/nmxYW **PA**	**Required** **AND** **4x daily testing*** **For non-MCT2D members*	**Required*** *3x daily injections or pump* **AND** *Frequent adjustments to treatment regimen necessary based on glucose testing results*	**Not Required**	*Assessed by a provider every six months for adherence to the prescribed CGM regimen and treatment plan*	**ALSO REQUIRED** *Documented compliance to physician-directed comprehensive diabetes management program.* *See Medical Policy for more info.*

COVERAGE GUIDE APPENDIX

2023 FORMULARY, STEP THERAPY & PRIOR AUTHORIZATION, AND DME POLICY LINKS & PROVIDER PHONE LINES

PAYOR	2023 FORMULARY URL	ST/PA GUIDELINES URL	DME POLICY URL	PROVIDE ASSISTANCE PHONE
Medicare	See MA plans	See MA plans	michmed.org/dJ8z3	800-633-4227
Medicaid	michmed.org/N2wn8	michmed.org/2VP94	n/a	800-292-2550
Blue Cross Complete	michmed.org/xNX5W	michmed.org/PJGPA	michmed.org/xNX5W	See region specific #
Molina	michmed.org/vJ4rz	n/a	michmed.org/gRWVY	855-326-5059
MA: Aetna	michmed.org/8NQrk	michmed.org/KqrMw	See Medicare/CMS policy listed above	800-624-0756
MA: BCBSM	michmed.org/DymRY	michmed.org/yqVYZ	See Medicare/CMS policy listed above	800-344-8525
MA: HAP	michmed.org/WAZqQ	michmed.org/vJV3A	See Medicare/CMS policy listed above	800-292-2550
MA: Humana	michmed.org/kQ894	michmed.org/kQkYr	See Medicare/CMS policy listed above	800-523-0023
MA: Priority	michmed.org/7NVGN	michmed.org/MMxnk	See Medicare/CMS policy listed above	800-942-4765
MA: United	michmed.org/YkDR3	n/a	See Medicare/CMS policy listed above	800-711-4555
MA: Wellcare	michmed.org/gRWDV	michmed.org/8NRev	See Medicare/CMS policy listed above	855-538-0454
Aetna	michmed.org/97Ay9	michmed.org/KqrMw	michmed.org/3xAqb	PA 800-414-2386
BCBSM	michmed.org/nmxVD	michmed.org/zRQZB	michmed.org/w8nMW	800-344-8525
Express Scripts	michmed.org/Dyq2x	michmed.org/3xAey	n/a	888-327-9791
HAP	michmed.org/qdV9P	PA: michmed.org/vJV3A ST: michmed.org/2VPGZ	n/a	888-427-6464
McLaren	michmed.org/QRr9A	n/a	n/a	888-327-0671
Priority *Traditional*	michmed.org/yq299	michmed.org/jm85Q	n/a	800-942-4765
Priority *Opimized*	michmed.org/BA4Kb	michmed.org/jm85Q	n/a	800-942-4765
United	michmed.org/7NJrY	michmed.org/Yk9Yb ST Mounjaro: michmed.org/gR89j	michmed.org/nmxYW	800-711-4555

What is STEP THERAPY?

When an insurance company requires a patient to try a cheaper alternative drug class before “stepping up” to a more expensive medication. In this case, most step therapy requirements are related to a trial of metformin.

What is PRIOR AUTHORIZATION?

The need to receive approval from a patient’s insurance company based on a justification letter from the prescriber as to prior drugs tried and/or specific patient history information that make a drug in the class a more preferred drug than others prior to the prescription being approved.

What are QUANTITY LIMITS?

When an insurance company limits how much of a medication can be prescribed (e.g. 3ML per 30 days) or the amount of supply that can be prescribed at one time (e.g. 30-day vs 90-day supply).

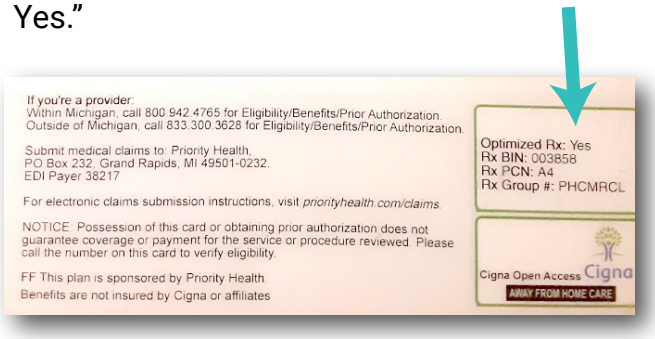
Pharmacy Carve Outs

These are the general coverage policies of each insurer, however, many insurers allow for pharmacy carve-outs, where pharmacy coverage is provided by a pharmacy benefits manager, and may not reflect the same formulary presented here. For example:

Priority Health “Optimized RX”

Optimized Rx is the formulary for all Priority Health small groups and is available as a rider for large groups.

Don't know if you have Optimized RX? Look on the back of your membership card.
If it's Optimized, it will say “Optimized Rx: Yes.”



REPORT A PROBLEM

Help us improve this tool by reporting out-of-date or incorrect informatiom.
Email **ccteam@mct2d.org** or submit feedback online at **michmed.org/ZYx5q**

Based on Q1-2022 Payer Policies. Subject to Change
See an error? Let us know at ccteam@mct2d.org
Last Updated: 2022-March 10

SGLT2i & GLP-1 RA

PATIENT ASSISTANCE PROGRAMS FOR MEDICARE PART D

MCT2D MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

BYDUREON BCISE & BYETTA | EXENATIDE XR

AstraZeneca — AZ&ME AstraZeneca Prescription Savings Program

AZ & ME PRESCRIPTION SAVINGS PROGRAM
1-800-292-6363

azandmeapp.com
Print Application: michmed.org/mVDX2

Annual Household Income Guidelines[1]	Under about $40K Under about $54K	MBI number on front of Medicare card is required	**How is income verified?**	"Soft" credit inquiry occurs via Date of Birth	**Individual can MAIL or Doctor's Office can FAX to 800-961-8323**

FARXIGA | DAPAGLIFLOZIN

AstraZeneca — AZ&ME AstraZeneca Prescription Savings Program

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INVOKANA | CANAGLIFLOZIN

Janssen — Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

JOHNSON & JOHNSON PATIENT ASSISTANCE FOUNDATION, INC.
1-800-652-6227

jjpaf.org
Print Application: michmed.org/JyD9P

Annual Household Income Guidelines[1]	Under about $58K Under about $78K	Must spend 4% or more of gross income on Rx drugs	**How is income verified?**	Credit report or copy of 1040 tax return	**MAIL or FAX to 888-526-5168**

JARDIANCE | EMPAGLIFLOZIN

Boehringer Ingelheim & Eli Lilly — Boehringer Ingelheim Cares Foundation

BI CARES PATIENT ASSISTANCE PROGRAM
1-800-556-8317

boehringer-ingelheim.us/our-responsibility/patient-assistance-program
Print Application: michmed.org/GzQ3K

Annual Household Income Guidelines[1]	Under about $32K Under about $44K	**PLUS** certain assets like retirement and second home	**How is income verified?**	Automatically using Experian, must provide last 4 digits of SSN	**Fax completed form to 866-851-2827**

SGLT2i & GLP-1 RA

PATIENT ASSISTANCE PROGRAMS FOR MEDICARE PART D

MCT2D MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

OZEMPIC & RYBELSUS — SEMAGLUTIDE
VICTOZA — LIRAGLUTIDE

NovoNordisk | NovoCare® Patient Affordability and Access Support

NOVO NORDISK PATIENT ASSISTANCE PROGRAM
1-866-310-7549

novocare.com/diabetes-overview/let-us-help/pap.html
Print Application: michmed.org/7VK4d

Annual Household Income Guidelines[1]	Under about $54K Under about $73K	**How is income verified?**	Must provide copy of document like; paystubs, 1040, W-2, or SSI, pension	**Doctor's Office must MAIL or FAX 866-441-4190**

TRULICITY — DULAGLUTIDE

Eli Lilly — Lilly Cares® Foundation

LILLY CARES FOUNDATION PATIENT ASSISTANCE PROGRAM
1-800-545-6962

lillycares.com
Print Application: michmed.org/vVQWx

Annual Household Income Guidelines[1]	Under about $54K Under about $73K	**How is income verified?**	Lilly Cares may contact you to request income documentation.	**ONLINE, MAIL or FAX to 844-431-6650**

MOUNJARO — TIRZEPATIDE

NO PATIENT ASSISTANCE PROGRAMS PER MOUNJARO.COM

STEGLATRO — ERTUGLIFLOZIN

Merck

STEGLATRO IS NOT A MERCK PRODUCT THAT SUPPORTS PATIENT ASSISTANCE PROGRAMS

[1] Income guidelines are estimates. For personalized referrals based on your income, insurance provider, and other factors, try **mat.org or or contact manufacturer program directly.**

medicine assistance tool.org

Last Updated: 2023-February

H.Diez, PharmD. - Sourced via Needymeds.org, manufacturer websites and mat.org.

MEDICATION COPAY SAVINGS CARDS

For Private/Commercial Insurance ONLY

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Getting Started

Find the medication you have been prescribed in the list below. Go to the listed manufacturer's website where you will be asked to fill out a simple form that checks your eligibility and may require an email address in order to send the electronic copay coupon. Copay savings programs do not have income specifications. Instead, there are maxmum copay savings caps, which may impact those with high deductables.

Patients with Medicare, Medicaid, or VA/Tricare coverage are NOT eligible to use these program. **Medicare Part D patients may be eligible for free supply via manufacturer Patient Assistance Programs**—See our Handout.

BYDUREON BCISE | EXENATIDE XR

BYDUREON BCISE SAVINGS CARD
1-866-680-9081

bydureon.com/bydureon-bcise/savings-and-support.html

MONTHLY COPAY
AS LITTLE AS
$0

MAXIMUM SAVINGS
$150 per month

CARD EXPIRATION
Not provided

NOTES
Mail-in rebate is available if mail-order pharmacy does not accept Savings Card and your insurance does not cover.

BYETTA | EXENATIDE XR

AZ & ME PRESCRIPTION SAVINGS PROGRAM
1-800-292-6363

azandmeapp.com

MONTHLY COPAY
AS LITTLE AS
$0

CARD EXPIRATION
None provided

NOTES
Only availble for those with NO prescription coverage

Last Updated: 2023-February
H.Diez, PharmD. Programs are subject to change, check manufacturer websites for most up-to-date eligibility.

MEDICATION COPAY SAVINGS CARDS

For Private/Commercial Insurance ONLY

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

FARXIGA DAPAGLIFLOZIN

FARXIGA SAVINGSRX CARD
1-844-631-3978

farxiga.com/savings-support

MONTHLY COPAY
AS LITTLE AS
$0

MAXIMUM SAVINGS
Up to $175 per 30-day supply

CARD EXPIRATION
None Provided

INVOKANA CANAGLIFLOZIN

JANSSEN CAREPATH SAVINGS PROGRAM
1-877-468-6526

invokana.com/savings-and-cost-support

MONTHLY COPAY
AS LITTLE AS
$0

MAXIMUM SAVINGS
Up to $175 per 30-day supply until 12/2022

CARD EXPIRATION
End of each calendar year

NOTES
Included combination products = Invokamet (canagliflozin/metformin IR) and Invokamet XR (canagliflozin/metformin XR).

JARDIANCE EMPAGLIFLOZIN

JARDIANCE SAVINGS CARD
1-866-279-8990

jardiance.com/heart-failure/savings-support

MONTHLY COPAY
AS LITTLE AS
$10

MAXIMUM SAVINGS
Up to $175 per 30-day supply until 12/2022

CARD EXPIRATION
12/31/2023

NOTES
Included combination products = Glyxambi (empagliflozin/linegliptin)

Last Updated: 2023-February
H.Diez, PharmD. Programs are subject to change, check manufacturer websites for most up-to-date eligibility.

MEDICATION COPAY SAVINGS CARDS

For Private/Commercial Insurance ONLY

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

MOUNJARO TIRZEPATIDE

MOUNJARO SAVINGS CARD
1-866-255-8661

mounjaro.com/savings-resources

MONTHLY COPAY
AS LITTLE AS
$25

MAXIMUM SAVINGS
$150 per month

CARD EXPIRATION
12/31/2023

NOTES
For a 1-month (4 pens) or 3-month (12 pens) prescription of Mounjaro

OZEMPIC SEMAGLUTIDE

NOVOCARES OZEMPIC SAVINGS CARD
1-877-304-6855

ozempicsavings.com

COPAY PER FILL
AS LITTLE AS
$25

MAXIMUM SAVINGS
$150 per month

CARD EXPIRATION
Good for up to 24 months

NOTES
If RX written for 3-month supply AND insurance coverage for 3-month fill, maximum savings is $450

RYBELSUS SEMAGLUTIDE

NOVOCARES RYBELSUS SAVINGS AND SUPPORT
1-877-304-6855

rybelsussavings.com

COPAY PER FILL
AS LITTLE AS
$10

MAXIMUM SAVINGS
$300 per month

CARD EXPIRATION
Good for up to 24 months

NOTES
Some Prescription Insurance GROUP numbers are no longer eligible. See website listed above for specifics. If RX written for 3 month supply AND insurance coverage for 3 supply, maximum savings is $900

Last Updated: 2023-February
H.Diez, PharmD. Programs are subject to change, check manufacturer websites for most up-to-date eligibility.

MEDICATION COPAY SAVINGS CARDS

For Private/Commercial Insurance ONLY

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

STEGLATRO ERTUGLIFLOZIN

SAVINGS COUPON FOR STEGLATRO
1-877-264-2454

steglatro.com/savings-offers

MONTHLY COPAY
AS LITTLE AS
$0

MAXIMUM SAVINGS
$583 per prescription

CARD EXPIRATION
02/28/2024

NOTES
The coupon is valid for use 12 times only. Savings are limited to the amount of your actual out-of-pocket cost, up to a maximum per prescription savings of $583

TRULICITY DULAGLUTIDE

TRULICITY SAVINGS CARD
1-844-878-4636

trulicity.com/savings-resources

MONTHLY COPAY
AS LITTLE AS
$25

MAXIMUM SAVINGS
$150 per month

CARD EXPIRATION
02/28/2024

VICTOZA LIRAGLUTIDE

NOVOCARES
1-877-304-6855

victozasavings.com

Program discontinued to new enrollees as of April 9, 2021.If you currently have a Victoza® Savings Card, you may continue to take advantage of its benefits until April 30, 2023.

REPORT A PROBLEM

Help us improve this tool by reporting out-of-date or incorrect information. Email **ccteam@mct2d.org** or submit feedback online at **michmed.org/ZYx5q**

Last Updated: 2023-February
H.Diez, PharmD. Programs are subject to change, check manufacturer websites for most up-to-date eligibility.

MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

Find these resources and more at MCT2D.org >>