MEDICAL NECESSITY CRITERIA

BRAND NAME
(generic)

INVOKAMET
(canagliflozin/metformin)

INVOKAMET XR
(canagliflozin/metformin extended-release)

INVOKANA
(canagliflozin)

Status: Client Requested Criteria
Type: Medical Necessity Criteria ***Ref # C11904-A***

CRITERIA FOR APPROVAL

1	The patient's drug benefit plan provides coverage for other drugs which may be considered for treating your patient. Can your patient's treatment be switched to a formulary drug? [Tech Note: If the prescriber agrees to switch to a preferred product, inform the prescriber that coverage for the prescribed, non-preferred drug/device is not provided]. Available Formulary Alternatives: Farxiga, Jardiance [If yes, provide your patient with a new prescription for the preferred product.]	Yes	No
2	Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
3	Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
4	Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? [If yes, then documentation is required for approval.] *[For internal use only, will not be printed on fax forms – PA Admin to enter required formulary alternatives: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative. If the requested drug is a combination product, at least 1 of the alternatives tried must be the 2 separate individual components taken concurrently (when both are on formulary) plus the remaining required number of alternatives. For products requested based on dosage form, all similar formulary dosage forms should be tried (e.g., insulin pre-filled syringes or pen devices).]* Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives (2 alternatives	Yes	No

CVS caremark™

in a class with 2 alternatives): Farxiga, Jardiance

Drug Name_____ Trial Year_____ Reason for Failure_____

Drug Name_____ Trial Year_____ Reason for Failure_____

Drug Name_____ Trial Year_____ Reason for Failure_____

[If yes, then no further questions.]

5 Does the patient have a contraindication to all the alternatives? Yes No

Mapping Instructions		
	Yes	**No**
1.	Deny, Inform prescriber to provide patient with a new prescription for the preferred product.	Go to 2
2.	Go to 3	Deny
3.	Go to 4	Deny
4.	Approve, 12 months	Go to 5
5.	Approve, 12 months	Deny

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (KC)
Date Written: 12/2017
Revised:
Reviewed: Medical Affairs: (LMS) 12/2017

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization.

_____ _____
Signature Date

_____
Client Name