Farxiga

I. Generic Name:
- a. Dapagliflozin (Farxiga®)

II. Medication Class:
- a. Sodium-glucose cotransporter 2 (SGLT2) inhibitor

III. FDA Approved Uses:
- a. Adults with type II diabetes mellitus (DM)
  - A. As an adjunct to diet and exercise to improve glycemic control
  - B. To reduce risk of hospitalization for heart failure in adults with type II DM and established cardiovascular disease or multiple cardiovascular risk factors
- b. Heart failure with reduced ejection fraction
  - A. To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure with reduced ejection fraction (NYHA class II-IV)

IV. Application of Criteria:
- a. The following criteria applies to Illinois Medicaid.

V. Criteria for Use:
- a. Member must be 18 years of age or older
- b. For Type II DM
  - A. Follow MeridianHealth Non-Preferred Policy M50.60
- c. For Heart Failure (without type II DM):
  - A. Medication is prescribed by or in consultation with a cardiologist
  - B. Documented diagnosis of chronic heart failure class II, III, or IV with reduced LV ejection fraction $\leq 40\%$
  - C. Member is receiving standard HF therapy for 4 or more weeks including the following (1 *and* 2) at maximally tolerated doses unless otherwise contraindicated:
    1. Beta blocker (e.g. carvedilol, metoprolol)
    2. ACEi/ARB (e.g. lisinopril, losartan)

VI. Required Medical Information:
- a. Current clinical documents must be submitted
- b. Charts showing compliance to previous therapy and office visits

VII. Contraindications:
- a. Known hypersensitivity to dapagliflozin

VIII. Not Approved If:

a. Patient does not meet criteria
b. Failure to provide the required medical information
c. eGFR is less than 30 ml/min/1.73m^2

IX. Length of Authorization:

a. Initial: Up to 1 year
b. Continuation: Up to 1 year

X. Dosing:

a. Type II DM: 5 mg once daily and may increase up to 10 mg once daily
b. Heart Failure: 10 mg once daily

XI. Criteria for continuation of therapy:

a. Initial therapy tolerated
b. Member is responding positively to therapy
c. If request is for a dose increase, the new dose may not exceed the FDA-approved maximum recommended dose

XII. Criteria for discontinuation of therapy:

a. Patient is noncompliant with medical or pharmacologic therapy
b. No demonstrable of improvement in clinical condition has occurred after initiation of drug therapy

XIII. References:

a. Farxiga (Dapagliflozin). Facts and Comparisons, 2020 Clinical Drug Information, LLC. Retrieved From: https://fco.factsandcomparisons.com/lco/action/search?q=farxiga&t=name&va
b. Farxiga [Package Insert]. Wilmington, DE; AstraZeneca Pharmaceuticals LP; May 2020.
c. Wexler, DJ. Initial management of blood glucose in adults with type 2 diabetes mellitus. Topic 1779. Version 57.0, ®UpToDate Online. June 2020.
d. Colucci, WS. Overview of the management of heart failure with reduced ejection fraction in adults. Topic 121085 Version 7.0, ®UpToDate Online. July 2020.

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Approved by: _____ Date: _____
CMO

Initial Approval:	02/12/2021
Revised:	
Annual Review:	
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