**LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES**
**CORE PHARMACY & THERAPEUTICS COMMITTEE**

Health Services
LOS ANGELES COUNTY

August 2021

TO: MHLA Clinics

FROM: Jeffrey Guterman, M.D.
Jean Pallares, Pharm.D.
Chairs, DHS Core Pharmacy and Therapeutics Committee

RE: DHS MHLA Formulary Update

## MY HEALTH LA FORMULARY

### Formulary Addition

| Drug Product | Comments |
|---|---|
| Sitagliptin (Januvia®) 25mg, 50mg, 100mg Tablets | 340B<br>Restricted to patient who has failed or is contraindicated to maximal doses of metformin + sulfonylureas + thiazolidinedione<br>Effective 8/02/2021 |
| Linagliptin (Tradjenta®) 5mg Tablet | 340B<br>Restricted to patient who has failed or is contraindicated to maximal doses of metformin + sulfonylureas + thiazolidinedione<br>Effective 8/02/2021 |
| Empagliflozin (Jardiance ®) 25mg Tablet | 340B<br>Restricted to MHLA Empagliflozin (Jardiance®) Prior Authorization Form [attached and on MHLA website]<br>Effective 8/02/2021 |
| Liraglutide 18mg/3ml (Victoza®) Injectable Pen | 340B<br>Restricted to MHLA Liraglutide (Victoza®) Prior Authorization Form [attached and on MHLA website]<br>Effective 8/02/2021 |

### Formulary Restriction Update

| Drug Product | Comments |
|---|---|
| Exenatide (Byetta®) 250mcg/ml Injectable Pen | 340B<br>MHLA Exenatide (Byetta®) Prior Authorization Form Update [attached and on MHLA website]<br>Effective 8/02/2021 |

### Formulary Removal

| Drug Product | Comments |
|---|---|
| Exenatide ER (Bydureon®) 2mg Injectable Pen | Bydureon® removed due to manufacturer discontinuation<br>Effective 8/02/2021 |

# MHLA Empagliflozin (Jardiance®) Prior Authorization Form

**Instructions**

1. Please fill out all sections of the form on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes, lab data, to support the PA request. Incomplete forms will be filed as incomplete.
2. Submit complete form along with complete documents via Email: priorauth@dhs.lacounty.gov or Fax: 310-669-5609
3. Dispensing Pharmacy: Acknowledge that completed forms fulfill approval criteria and have been submitted via email/fax; claims will process following acknowledgment as prompted when billing online [clarification code 7]. Claims with PA forms are subject to audit.

**Notes**

1. Authorizations are limited to a maximum of **twelve (12) months** of therapy.
   Additional authorization is required for any use after this initial 12-month period.
2. Please complete **ALL** areas below, as incomplete prior authorization requests **MAY AFFECT THE OUTCOME** of this request.

| **Patient Information: This must be filled out COMPLETELY to ensure HIPAA compliance** | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | MI: | Phone Number: | |
| Address: | City: | | CA | Zip Code: | |
| Date of Birth: | ☐ Male ☐ Female | Height: Weight: | | Allergies: | |
| Patient's Authorized Representative (if applicable): | | Authorized Representative Phone Number: | | | |
| **Insurance/Coverage Information** | | | | | |
| Primary Insurance/Coverage Name: **My Health LA** | | MHLA Patient ID Number: | | | |
| **Prescriber Information** | | | | | |
| First Name: | Last Name: | | Specialty: | | |
| Address: | City: | | CA | Zip Code: | |
| Requestor (if different than prescriber): | | Office Contact Person: | | | |
| NPI Number (individual): | | Phone Number: | | | |
| DEA Number (if required): | | Fax Number (in HIPAA compliant area): | | | |
| Email Address: | | | | | |
| **Jardiance® Prescription Information** | | | | | |
| Dose/Strength: | Frequency: | Length of Therapy/#Refills: | | Quantity: | |
| ☐ New Therapy ☐ Renewal | | | | | |
| If Renewal: Date Therapy Initiated: | | Duration of Therapy (specific dates): | | | |
| How did the patient receive the medication? ☐ Patient Assistance Program. If PAP denied, please attach denial letter. ☐ Other (explain): _____ | | | | | |

| **Medication History for This Condition** | | |
|---|---|---|
| **Medication/Therapy** (Specify Drug Name and Dosage) | **Duration of Therapy** (Specify Dates) | **Response/Reason for Failure/Allergy** |
| | | |



LA County DHS P&T Committee Approved: 6/2021

# MHLA Empagliflozin (Jardiance®) Prior Authorization Form Continued

| Patient Name: | MHLA Patient ID#: |
|---|---|

**STEP 1: EXCLUSION CRITERIA** *(If any of the following criteria apply, the patient does **NOT** qualify for empagliflozin use)*

| | |
|---|---|
| Patient diagnosed with Type 1 Diabetes or for treatment of diabetic ketoacidosis | Patient currently admitted for inpatient care |
| Patient has known hypersensitivity to empagliflozin or any excipients in empagliflozin | Patient has recurrent mycotic genital infections |
| Patient has eGFR of less than 45mL/min/1.73m$^2$ | *Caution: use in uncircumcised males, provider should discuss cleaning/hygiene routines |
| Patient is in the second or third trimester of pregnancy or breastfeeding | Patient is under 18 years of age |

☐ Patient has no exclusion criteria listed above

**STEP 2a: APPROVAL CRITERIA AS 2nd-LINE THERAPY FOR CARDIOVASCULAR RISK REDUCTION IN A PATIENT WITH T2DM and CAD** *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval)*
**Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

| | |
|---|---|
| ☐ | Diagnosis of Type 2 Diabetes with a history of coronary artery disease (CAD) |
| ☐ | Patient on Metformin or has contraindication/intolerance to Metformin and requires add-on of Empagliflozin for cardiovascular protection<br>*for coronary artery disease (CAD) patients, empagliflozin (Jardiance®) may be used concurrently with insulin |
| ☐ | Patient has an eGFR of greater than/equal to 45mL/min/1.73m$^2$; patient's current eGFR: _____ mL/min/1.73m$^2$ |

**STEP 2b: APPROVAL CRITERIA AS 2nd-LINE THERAPY FOR PROTEINURIA** *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval)*. **Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

| | |
|---|---|
| ☐ | Diagnosis of Type 2 Diabetes with Urine MicAlbumin-to-Creatinine Ratio of > 300mg/g |
| ☐ | Patient has an eGFR of greater than or equal to 45mL/min/1.73m2; patient's current eGFR: _____ mL/min/1.73m2 |
| ☐ | Patient currently on or has contraindication to angiotensin converting enzyme inhibitor (ACE-i) or angiotensin receptor blocker (ARB) |

**STEP 2c: APPROVAL CRITERIA AS 3rd or 4th-LINE THERAPY FOR T2DM** *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval)*. **Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐ New Therapy **OR** ☐ Continuation of therapy; HbA1c **MUST BE** less than 8%

| | |
|---|---|
| ☐ | Diagnosis of Type 2 Diabetes and has a HbA1c between 0.5% and 2% above HbA1c target (see HbA1c target expected practice)<br>Target HbA1c _____, Current HbA1c _____ |
| ☐ | Patient is not currently on insulin therapy |
| ☐ | Patient has an eGFR of greater than or equal to 45mL/min/1.73m2; patient's current eGFR: _____ mL/min/1.73m2 |
| ☐ | Patient has failed/contraindication or is intolerant to maximal doses of metformin + sulfonylurea + thiazolidinedione (using empagliflozin as 4th line agent) |

**STEP 3: DOSAGE** *(Check the appropriate dosage)*

| | |
|---|---|
| ☐ Empagliflozin (Jardiance®) 25 mg; half tablet daily [effective dose of 12.5mg]<br>*(if on a sulfonylurea, sulfonylurea dose should also be halved when initiating empagliflozin to prevent hypoglycemia and can be increased back to full dose if no hypoglycemia in 1 month)* | ☐ Other _____<br>(Specify dose and frequency: explain in Step 4) |

**STEP 4: ADDITIONAL EXPLANATION** *(For additional comments, please attach to form)*

**STEP 5: ATTACH RELEVANT PROGRESS NOTE, LABS, and CURRENT MEDS** *(Required)*

**STEP 6: PRESCRIBER SIGNATURE**

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature**:_____ **Date**: _____



***Plan Use Only:***

**Pharmacy Review:** Approval criteria met? ☐ **YES** ☐ **NO**
See instructions at top of form for next step following review.

| | |
|---|---|
| Patient's A1c %: | Date of A1c: |
| Date Received: | Date of Decision: |
| Pharmacist Reviewer: | |

**Medical Review:** ☐ **Approved** ☐ **Denied**

| | |
|---|---|
| Date Received: | Date of Decision: |
| CMO or Designee: | |



LA County DHS P&T Committee Approved: 6/2021

# MHLA Liraglutide (Victoza®) Prior Authorization Form

**Instructions**

1. Please fill out all sections of the form on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes, lab data, to support the PA request. Incomplete forms will be filed as incomplete.
2. Submit complete form along with complete documents via Email: priorauth@dhs.lacounty.gov or Fax: 310-669-5609

**Notes**

1. Authorizations are limited to a maximum of **twelve (12) months** of therapy. Additional authorization is required for any use after this initial 12-month period.
2. Please complete **ALL** areas below, as incomplete prior authorization requests **MAY AFFECT THE OUTCOME** of this request.

| **Patient Information: This must be filled out COMPLETELY to ensure HIPAA compliance** | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | MI: | Phone Number: | |
| Address: | City: | | CA | Zip Code: | |
| Date of Birth: | ☐ Male ☐ Female | Height: | Weight: | Allergies: | |
| Patient's Authorized Representative (if applicable): | | Authorized Representative Phone Number: | | | |
| **Insurance/Coverage Information** | | | | | |
| Primary Insurance/Coverage Name: **My Health LA** | | MHLA Patient ID Number: | | | |
| **Prescriber Information** | | | | | |
| First Name: | Last Name: | | Specialty: | | |
| Address: | City: | | CA | Zip Code: | |
| Requestor (if different than prescriber): | | Office Contact Person: | | | |
| NPI Number (individual): | | Phone Number: | | | |
| DEA Number (if required): | | Fax Number (in HIPAA compliant area): | | | |
| Email Address: | | | | | |
| **Victoza® Prescription Information** | | | | | |
| Dose/Strength: | Frequency: | Length of Therapy/#Refills: | | Quantity: | |
| ☐ New Therapy ☐ Renewal | | | | | |
| If Renewal: Date Therapy Initiated: | | Duration of Therapy (specific dates): | | | |
| How did the patient receive the medication? ☐ Patient Assistance Program. If PAP denied, please attach denial letter. ☐ Other (explain): _____ | | | | | |

| **Medication History for This Condition** | | |
|---|---|---|
| **Medication/Therapy** (Specify Drug Name and Dosage) | **Duration of Therapy** (Specify Dates) | **Response/Reason for Failure/Allergy** |
| | | |



LA County DHS P&T Committee Approved: 6/2021

# MHLA Liraglutide (Victoza®) Prior Authorization Form Continued

| Patient Name: | MHLA Patient ID#: |
|---|---|

## STEP 1: EXCLUSION CRITERIA *(If any of the following criteria apply, the patient does **NOT** qualify for exenatide use)*

| | |
|---|---|
| Patient diagnosed with Type 1 Diabetes | Patient has severe gastrointestinal disease, including gastroparesis |
| Patient with a personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) | Patient has known hypersensitivity to liraglutide or any of the product components |
| Patient has a history of pancreatitis | Patient on concurrent dipeptidyl peptidase (DPP-4) inhibitor therapy |
| Patient currently admitted for inpatient care | Patient on concurrent sodium/glucose cotransporter 2 (SGLT2) inhibitor therapy |

☐ Patient has no exclusion criteria listed above

## STEP 2a: APPROVAL CRITERIA for DM2 with CAD *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval. **None** of the exclusion criteria above apply.)*

**Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐ Diagnosis of Type 2 Diabetes with a history of coronary artery disease

☐ Patient on Metformin or has contraindication/intolerance to Metformin and requires add-on of liraglutide for cardiovascular protection with contraindication/intolerance to empagliflozin (Jardiance)

## STEP 2b: APPROVAL CRITERIA FOR DM2 without CAD *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval. **None** of the exclusion criteria above apply.)*

**Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐ New Therapy; HbA1c greater than or equal to 8% **OR** ☐ Continuation of therapy; HbA1c **MUST BE** less than 8%

☐ Diagnosis of Type 2 Diabetes

☐ Patient has an A1c ≥ 8% at initiation of therapy; A1c < 8% as continuation of therapy.
Patient's current A1c _____ Date _____

☐ Patient has failed or is intolerant/contraindicated to maximal doses of metformin + sulfonylurea + thiazolidinedione AND is contraindicated/intolerant to empagliflozin (Jardiance), please specify on previous page in the medication history section

## STEP 3: DOSAGE *(Check the appropriate dosage)*

| | | |
|---|---|---|
| ☐ 0.6 mg subcutaneously daily x 1 week, then increase to 1.2 mg subcutaneously daily | ☐ 1.2 mg subcutaneously daily | ☐ 1.8 mg subcutaneously daily |

## STEP 4: ADDITIONAL EXPLANATION *(For additional comments, please attach to form)*

## STEP 5: ATTACH RELEVANT PROGRESS NOTE, LABS, and CURRENT MEDS *(Required)*

## STEP 6: PRESCRIBER SIGNATURE

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature**:_____ **Date**: _____



## ***Plan Use Only:***

**Pharmacy Review:** Approval criteria met? ☐ **YES** ☐ **NO**
See instructions at top of form for next step following review.

| | |
|---|---|
| Patient's A1c %: | Date of A1c: |
| Date Received: | Date of Decision: |
| Pharmacist Reviewer: | |

**Medical Review:** ☐ **Approved** ☐ **Denied**

| | |
|---|---|
| Date Received: | Date of Decision: |
| CMO or Designee: | |



LA County DHS P&T Committee Approved: 6/2021

# MHLA Exenatide (Byetta®) Prior Authorization Form

**Instructions**

1. Please fill out all sections of the form on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes, lab data, to support the PA request. Incomplete forms will be filed as incomplete.
2. Submit complete form along with complete documents via Email: priorauth@dhs.lacounty.gov or Fax: 310-669-5609

**Notes**

1. Authorizations are limited to a maximum of **twelve (12) months** of therapy. Additional authorization is required for any use after this initial 12-month period.
2. Please complete **ALL** areas below, as incomplete prior authorization requests **MAY AFFECT THE OUTCOME** of this request.

| **Patient Information: This must be filled out COMPLETELY to ensure HIPAA compliance** | | | |
|---|---|---|---|
| First Name: | Last Name: | MI: | Phone Number: |
| Address: | City: | CA | Zip Code: |
| Date of Birth: | ☐ Male ☐ Female | Height: Weight: | Allergies: |
| Patient's Authorized Representative (if applicable): | | Authorized Representative Phone Number: | |
| **Insurance/Coverage Information** | | | |
| Primary Insurance/Coverage Name: **My Health LA** | | MHLA Patient ID Number: | |
| **Prescriber Information** | | | |
| First Name: | Last Name: | Specialty: | |
| Address: | City: | CA | Zip Code: |
| Requestor (if different than prescriber): | | Office Contact Person: | |
| NPI Number (individual): | | Phone Number: | |
| DEA Number (if required): | | Fax Number (in HIPAA compliant area): | |
| Email Address: | | | |
| **Byetta® Prescription Information** | | | |
| Dose/Strength: | Frequency: | Length of Therapy/#Refills: | Quantity: |
| ☐ New Therapy ☐ Renewal | | | |
| If Renewal: Date Therapy Initiated: | | Duration of Therapy (specific dates): | |
| How did the patient receive the medication? ☐ Patient Assistance Program. If PAP denied, please attach denial letter. ☐ Other (explain): _____ | | | |

| **Medication History for This Condition** | | |
|---|---|---|
| **Medication/Therapy** (Specify Drug Name and Dosage) | **Duration of Therapy** (Specify Dates) | **Response/Reason for Failure/Allergy** |
| | | |



LA County DHS P&T Committee Approved: 6/2021

# MHLA Exenatide (Byetta®) Prior Authorization Form Continued

| Patient Name: | MHLA Patient ID#: |
|---|---|

## STEP 1: EXCLUSION CRITERIA *(If any of the following criteria apply, the patient does **NOT** qualify for exenatide use)*

| | |
|---|---|
| Patient diagnosed with Type 1 Diabetes or for treatment of diabetic ketoacidosis | Patient has severe gastrointestinal disease, including gastroparesis |
| Patient with a personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) | Patient has known hypersensitivity to exenatide or any of the product components |
| Patient has a history of pancreatitis | Patient on concurrent dipeptidyl peptidase (DPP-4) inhibitor therapy |
| History of drug induced immune mediated thrombocytopenia from exenatide products | Patient on concurrent sodium/glucose cotransporter 2 (SGLT2) inhibitor therapy |
| Patient currently admitted for inpatient care | Pediatric patient - safety and effectiveness has not been established |

Patient has severe renal impairment (CrCl <30 mL/min) or end-stage renal disease. **Patient's current Scr** _____ **Date** _____ **CrCl** _____

| | |
|---|---|
| ☐ | Patient has no exclusion criteria listed above |

## STEP 2: APPROVAL CRITERIA *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval. **None** of the exclusion criteria above apply.)*

**Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.

☐ New Therapy; HbA1c greater than or equal to 8% **OR** ☐ Continuation of therapy; HbA1c **MUST BE** less than 8%

| | |
|---|---|
| ☐ | Diagnosis of Type 2 Diabetes |
| ☐ | Patient has an A1c ≥ 8% at initiation of therapy; A1c < 8% as continuation of therapy.<br>Patient's current A1c _____ Date _____ |
| ☐ | Patient has failed or is intolerant/contraindicated to maximal doses of metformin + sulfonylurea + thiazolidinedione AND is contraindicated/intolerant to empagliflozin (Jardiance), please specify on previous page in the medication history section<br><br>**Please note that the formulary preferred GLP-1 agonist Liraglutide (Victoza®) is preferred in patient with high cardiovascular risk |

## STEP 3: DOSAGE *(Check the appropriate dosage)*

| | |
|---|---|
| ☐ 5 mcg subcutaneously twice daily within 60 minutes before the morning and evening meals | ☐ 10 mcg subcutaneously twice daily within 60 minutes before morning and evening meals |

## STEP 4: ADDITIONAL EXPLANATION *(For additional comments, please attach to form)*

## STEP 5: ATTACH RELEVANT PROGRESS NOTE, LABS, and CURRENT MEDS *(Required)*

## STEP 6: PRESCRIBER SIGNATURE

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature**: _____ **Date**: _____



## ***Plan Use Only:***

**Pharmacy Review:** Approval criteria met? ☐ **YES** ☐ **NO**
See instructions at top of form for next step following review.

| | |
|---|---|
| Patient's A1c %: | Date of A1c: |
| Date Received: | Date of Decision: |
| Pharmacist Reviewer: | |

| | | |
|---|---|---|
| **Medical Review:** | ☐ **Approved** | ☐ **Denied** |
| Date Received: | Date of Decision: | |
| CMO or Designee: | | |