Effective Date: 01/01/2022
Reviewed: 10/2021, 8/2022, 4/2023
Scope: Medicaid

Trijardy XR (empagliflozin, linagliptin, metformin) Step Therapy Criteria

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

A. Patient is 18 years or older; AND
B. Patient has not achieved adequate glucose control using an adequate/maximized dose of metformin, or a formulary Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitor or combination product (i.e., Farxiga, Invokana, Invokamet, Invokamet XR, Jardiance, Steglatro).

II. QUANTITY LIMIT

- Trijardy XR 10mg/5mg/1000mg: 1 tablet per day
- Trijardy XR 25mg/5mg/1000mg: 1 tablet per day
- Trijardy XR 5mg/2.5mg/1000mg: 2 tablets per day
- Trijardy XR 12.5mg/2.5mg/1000mg: 2 tablets per day

III. COVERAGE DURATION

- 12 months

Neighborhood Health Plan OF RHODE ISLAND™