JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS006
		Effective Date	04/30/2007
		Review Date	01/19/2022
	Subject **Insulin Products**	*Revision Date*	01/19/2022
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: Basaglar, Humalog, Insulin, Lantus, Levemir, Novolog, Semglee, Toujeo, Tresiba

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I. POLICY

A. Non-formulary Insulin therapy will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20. The Insulin Pen will require prior authorization for outpatient prescription drug benefit coverage to ensure this medication is used only when clinically appropriate.
   1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
   2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. **Short-acting Insulin:**
   1. Non-formulary short-acting insulin pens and vials may be approved if **all** of the following criteria are met:
      a. Diagnosis of Type 1 or Type 2 diabetes **AND**
      b. Member has had trial and inadequate response with optimized dosing of formulary Admelog SoloStar or vial

B. **Long-acting Insulin:**
   1. Non-formulary long-acting insulin pens and vials, including, but not limited to, **Levemir**, **Lantus**, and **Tresiba,** may be approved if the following criteria are met:
      a. Diagnosis of Type 1 or Type 2 diabetes **AND**
      b. Documented trial and inadequate response with optimized dosing of formulary Basaglar or Semglee
   2. **Toujeo** (insulin glargine 300 units/mL) may be approved if members meet all of the following:
      a. The member is 18 years of age or older.
      b. Documentation has been provided showing that the member's fasting blood sugars have not been able to be controlled with an adequate trial of insulin glargine 100 units/mL.
      c. The member is using a minimum of 60 units of insulin glargine per day.
      d. Documentation has been provided showing the member has been counseled regarding the risk of dosing errors with this higher concentrated insulin product.

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval shall be granted for 6 months.
B. Continuation of therapy may be extended to the term of enrollment, if adequate response is documented.

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IV. EXCLUSIONS

A. Insulin products will not be approved for non-covered uses.

B. Toujeo will NOT be approved for the following:
   1. Patient or prescriber's preference for Toujeo
   2. Patient or prescriber's desire for a smaller injection volume
   3. History of non-compliance with previous insulin therapy

C. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
4/20/2016	Authorization period clarification; removal of initation request process
11/1/2016	Addition of clinical criteria for Toujeo
11/14/2016	Addition of clinical criteria for Tresiba
01/20/2017	Clarification of coverage criteria for both Short-acting and Long-acting insulin pens
07/27/2017	Updated Exclusion section regarding physician samples
09/14/2018	Clarification of coverage criteria for Short-acting insulin pens
04/26/2019	Clarification of criteria based on P&T-approved formulary changes effective 4/1/2019
01/19/2022	Included Semglee in the criteria as a preferred long-acting product; updated Toujeo criteria

Review/Revision Dates: 03/01/2014, 04/20/2016, 11/1/2016, 11/14/2016, 1/18/2017, 1/20/2017, 7/27/2017, 9/14/2018, 04/26/2019, 01/19/2022