AETNA BETTER HEALTH®
Prior Authorization guideline for Jardiance® (empagliflozin)

Authorization guideline

Jardiance is approved when one of the following is met:

A. Diagnosis of Diabetes Mellitus Type 2 with established cardiac disease

B. Documented inadequate response or intolerance with Steglatro or Segluromet

Approval Duration: Indefinite

Medically Necessary — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.
The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

References:
2. Clinical Resource, Drugs for Type 2 Diabetes. Pharmacist’s Letter/Prescriber’s Letter. July 2018