Prior Authorization Criteria for Thiazolidinediones (TZDs)

Background

The thiazolidinediones (TZDs) includes pioglitazone agents (Actos, Actos plus Met, Duetact) and rosiglitazone agents (Avandia, Avandamet, and Avandaryl); and are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus in multiple clinical settings. Thiazolidinediones (TZDs) exert their antihyperglycemic effect only in the presence of endogenous insulin. Therefore TZDs should not be used to treat type 1 diabetes or diabetic ketoacidosis, as they would not be effective in these settings.

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee. These criteria have an automated component, based on review of prescriptions filled using the DoD pharmacy benefit at retail network pharmacies, military treatment facilities, or the Mail Order Pharmacy.

<table>
<thead>
<tr>
<th>Prior Authorization Criteria for Thiazolidinediones (TZDs)</th>
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</thead>
<tbody>
<tr>
<td>Coverage is approved if the patient has a diagnosis of type 2 diabetes mellitus AND meets one of the following criteria:</td>
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<tr>
<td>1. Has not achieved adequate glycemic control on at least ONE of the following</td>
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<tr>
<td>• metformin (alone or in combination)</td>
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<tr>
<td>• a sulfonylurea (alone or in combination)</td>
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<tr>
<td>2. Has experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis.</td>
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<tr>
<td>3. Has experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment.</td>
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<tr>
<td>4. Has a contraindication to BOTH metformin and a sulfonylurea.</td>
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</tbody>
</table>

Automated review is performed based on oral antidiabetic prescriptions, and prior metformin or sulfonylurea prescriptions, dispensed during the previous 180 days at a Military Treatment Facility (MTF), a retail network pharmacy, or the mail order pharmacy.

Criteria approved through the DoD P&T Committee process

www.tricare.mil is the official Web site of the Defense Health Agency, a component of the Military Health System
DHHQ, 7700 Arlington Blvd, Falls Church, VA 22042
To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program (USFHP).

**Step 1**

**Please complete patient and physician information (please print):**

Patient Name: ____________________________  Physician Name: ____________________________

Address: ____________________________  Address: ____________________________

Sponsor ID #: ____________________________  Phone #: ____________________________

Date of Birth: ____________________________  Secure Fax #: ____________________________

**Step 2**

**Please complete the clinical assessment:**

1. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?
   - Yes
   - No
   *Sign and date below
   *Proceed to question 2

2. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?
   - Yes
   - No
   *Sign and date below
   *Proceed to question 3

3. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?
   - Yes
   - No
   *Coverage not approved

**Step 3**

**I certify the above is true to the best of my knowledge.**

Please sign and date:

__________________________  ____________________________

Prescriber Signature  Date

Effective date: 13 April 2011

Prior authorization criteria and a copy of this form are available at: http://usfamilyhealth.org/for-providers/downloadable-forms. This prior authorization has no expiration date.

MAIL ORDER and RETAIL

- The provider may call: 1-877-880-7007
  or the completed form may be faxed to: 1-617-562-5296

- The patient may attach the completed form to the prescription and mail it to: ATTN: Pharmacy, 77 Warren St, Brighton, MA 02135

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