PRIOR AUTHORIZATION REQUEST

GLP-1 PRODUCTS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for continuation of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested glucagon-like peptide-1 (GLP-1) product? [If no, skip to question 7.]	Yes	No

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3	Has the patient been receiving medication samples for the requested GLP-1 product? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan for the requested GLP-1 product? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Type 2 Diabetes Mellitus (If checked, go to 8) [] Reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus who are at high risk for these events (If checked, go to 22) [] Other (If checked, no further questions)		
8	Has laboratory documentation been submitted to confirm the diagnosis of type 2 diabetes mellitus as evidenced by any of the following: A) Fasting glucose greater than 126 milligram per deciliter (mg/dL), B) Two hour glucose tolerance test greater than 200 mg/dL, C) Hemoglobin A1c of 6.5 percent or greater, or D) Symptoms of hyperglycemia and a random plasma glucose greater than or equal to 200 mg/dL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Is the patient CURRENTLY taking metformin? [If yes, skip to question 12.]	Yes	No
10	Did the patient have a previous inadequate response or adverse effect from metformin? [If yes, skip to question 12.]	Yes	No
11	Does the patient have any of the following contraindications to metformin: A) Renal dysfunction (serum creatinine greater than 1.4 mg per dL for females or greater than 1.5 mg per dL for males), B) Metabolic acidosis, C) Diabetic ketoacidosis?	Yes	No

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[If no, no further questions.]

12 What drug is being requested?

[] Trulicity (If checked, go to 13)

[] Rybelsus (If checked, go to 17)

[] Bydureon pen (If checked, go to 13)

[] Victoza 2-pak (If checked, go to 13)

[] Byetta (If checked, go to 15)

[] Mounjaro (If checked, go to 18)

[] Ozempic SUBCUTANEOUS (If checked, go to 17)

[] Liraglutide 2-pak (If checked, go to 18)

13 How old is the patient?

[] Greater than or equal to 10 years of age and less than or equal to 17 years of age (If checked, go to 14)

[] Greater than or equal to 18 years of age (If checked, go to 16)

[] Other (If checked, no further questions)

14	Has the patient tried and failed liraglutide? [If yes, skip to question 19.] [If no, no further questions.]	Yes	No
15	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
16	Has the patient tried and failed ALL of the following formulary GLP-1 agonists for at least 3 months: A) Mounjaro, B) Ozempic, C) Rybelsus, D) liraglutide? [If yes, skip to question 19.] [If no, no further questions.]	Yes	No
17	Is the patient greater than or equal to 18 years of age? [If yes, skip to question 19.] [If no, no further questions.]	Yes	No
18	Is the patient greater than or equal to 10 years of age? [If no, no further questions.]	Yes	No
19	Will the medication be used concurrently with other GLP-1 medications? [If yes, no further questions.]	Yes	No

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20	Will the medication be used for the sole purpose of weight loss? [If yes, no further questions.]	Yes	No
21	Does the requested dose exceed the FDA recommended dosing for the indication? [Note: Dosing: Once weekly subcutaneous injection.] [No further questions.]	Yes	No
22	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
23	Does the patient have a confirmed diagnosis of type 2 diabetes mellitus as evidenced by any of the following: A) Fasting glucose greater than 126 milligram per deciliter (mg/dL), B) Two-hour glucose tolerance test greater than 200 mg/dL, C) Hemoglobin A1c of 6.5 percent or greater, or D) Symptoms of hyperglycemia and a random plasma glucose greater than or equal to 200 mg/dL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	What drug is being requested? [] Rybelsus (If checked, go to 25) [] Ozempic TABLET (If checked, go to 25) [] Other (If checked, no further questions)		
25	Does the patient have established cardiovascular disease as evidenced by at least one of the following: A) Prior Myocardial Infarction, B) Prior Stroke (Ischemic or Hemorrhagic), C) Symptomatic Peripheral Arterial Disease (PAD) as demonstrated by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), D) Peripheral arterial revascularization procedure, amputation due to atherosclerotic disease, Chronic kidney disease associated with increased cardiovascular risk? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Does the provider attest that the patient has been screened for all black box warnings and all contraindications? [Note: Patient assessed for personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2).] [If no, no further questions.]	Yes	No
27	Will the medication be used concurrently with other GLP-1 medications? [If yes, no further questions.]	Yes	No
28	Does the requested dose exceed the FDA recommended dosing for the indication?	Yes	No

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[Note: Dosing: One tablet by mouth once daily.]

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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