

GLP-1 (GLUCAGON-LIKE PEPTIDE-1) AGONISTS

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
 Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? Yes No
2. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
If yes, please specify contraindication(s): _____
3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____
4. Will the patient be using the requested agent in combination with a DPP-4 containing agent (e.g., Alogliptin/metformin, Alogliptin/pioglitazone, Brynovin, Januvia, Janumet, Janumet XR, Jentadueto, Jentadueto XR, Kazano, Kombiglyze XR, Nesina, Onglyza, Oseni, Tradjenta, Trijardy, Zituvio, Zituvimet), (Zituvimet XR) the requested indication? Yes No
5. Will the patient be using the requested agent in combination with another GLP-1 receptor agonist agent (e.g., Saxenda, Wegovy, Zepbound, Bydureon, Byetta, Exenatide, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza)? Yes No
6. Will the patient be using the requested strength in combination with another strength of the requested agent for the requested indication? Yes No
7. Does the patient have a diagnosis of type 2 diabetes mellitus? Yes No
If yes, has the patient’s diagnosis been confirmed by ONE of the following lab tests? **Please note, chart notes or a copy of lab test results confirming your diagnosis are required for review.**
 - An A1C greater than or equal to 6.5%
 - A fasting plasma glucose greater than or equal to 126 mg/dL
 - A 2-hour plasma glucose greater than or equal to 200 mg/dL during OGTT
 - A random plasma glucose greater than or equal to 200 mg/dL, along with symptoms of hyperglycemia
 - None of the above

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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8. Please explain why this specific medication, strength, dose, and quantity were chosen over other options. Please include any relevant reasons such as previous use of same or higher dose, request for maintenance therapy, beneficial response to current dose, allergies, side effects from alternatives strengths/doses, evidence to support use of requested quantity (dose) that cannot be achieved with a lower quantity of a higher strength/dose, or clinical justification for exceeding the FDA maximum dose/duration. **Please note, documentation may be required:** _____

For Byetta, Exenatide, Liraglutide, Victoza:

9. Is the patient currently being treated with the requested agent, AND is the patient currently stable on the requested agent? Yes No

10. Is the requested agent medically necessary and appropriate for the patient? Yes No

11. Has the patient tried and had an inadequate response to semaglutide (Ozempic OR Rybelsus)? Yes No

If no, answer the following questions:

- Was semaglutide (Ozempic OR Rybelsus) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

- Is semaglutide (Ozempic OR Rybelsus) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No

- Is semaglutide (Ozempic OR Rybelsus) not in the best interest of the patient based on medical necessity? Yes No

- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as semaglutide (Ozempic OR Rybelsus) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No

- Does the patient have an intolerance or hypersensitivity to semaglutide (Ozempic OR Rybelsus)? Yes No
If yes, please explain intolerance/hypersensitivity: _____

- Does the patient have an FDA labeled contraindication to semaglutide (Ozempic OR Rybelsus)? Yes No
If yes, please specify FDA labeled contraindication: _____

12. Has the patient tried and had an inadequate response to dulaglutide (Trulicity)? Yes No

If no, answer the following questions:

- Was dulaglutide (Trulicity) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

- Is dulaglutide (Trulicity) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No

- Is dulaglutide (Trulicity) not in the best interest of the patient based on medical necessity? Yes No

- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as dulaglutide (Trulicity) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

- Does the patient have an intolerance or hypersensitivity to dulaglutide (Trulicity)? Yes No
If yes, please explain intolerance/hypersensitivity: _____

- Does the patient have an FDA labeled contraindication to dulaglutide (Trulicity)? Yes No
If yes, please specify FDA labeled contraindication: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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13. Has the patient tried and had an inadequate response to tirzepatide (Mounjaro)? Yes No
 If no, answer the following questions:
- Was tirzepatide (Mounjaro) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 - Is tirzepatide (Mounjaro) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
 - Is tirzepatide (Mounjaro) not in the best interest of the patient based on medical necessity? Yes No
 - Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as tirzepatide (Mounjaro) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 - Does the patient have an intolerance or hypersensitivity to tirzepatide (Mounjaro)? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
 - Does the patient have an FDA labeled contraindication to tirzepatide (Mounjaro)? Yes No
 If yes, please specify FDA labeled contraindication: _____

For Mounjaro 2.5 mg:

14. Does the requested quantity (dose) exceed 4 pens per 180 days? Please note, the quantity limit for the 2.5 mg strength is 4 pens per 180 days. All other strengths have a quantity limit of 4 pens per 28 days. Yes No
 If yes, is the intended use for maintenance therapy? Yes No
 If yes, does the patient have an inability to use an FDA labeled strength indicated for maintenance therapy? Yes No
 If yes, please explain: _____
- If yes, has the patient had clinical benefit on the lower requested strength from baseline (prior to initiation of the requested agent and strength)? Yes No
 If yes, please provide supporting information: _____

For renewal requests:

15. Has the patient had clinical benefit with a targeted agent in this policy (i.e., Bydureon BCise, Mounjaro, Ozempic, Rybelsus, Trulicity, Byetta, Exenatide, Victoza, liraglutide)? Yes No

By submitting this form, you are attesting to the following:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. Medical records specific to this case, as stated in the criteria, for this patient may be requested in order to verify this information, consistent with applicable law.

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
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BCBSNM: 800.544.1378
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