SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Incretin Mimetic Drugs

Drug Requested: (Check below the drug that applies)

Preferred Drugs *Prior authorization required for Preferred drugs	
❑ **Byetta®**	❑ **Trulicity™**
❑ **Victoza®**	
Non-Preferred Drugs *Require prior authorization and trial and failure of 2 (two) preferred drugs	
❑ **Bydureon™ Bcise SQ**	❑ **liraglutide (generic Victoza)**
❑ **Mounjaro®**	❑ **Ozempic®**
❑ **Rybelsus®**	❑ **Soliqua® 100/33**
❑ **Tanzeum™**	❑ **Xultophy®**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Will the member be discontinuing a previously prescribed glucagon-like peptide (GLP-1) receptor agonist medication if approved for requested medication?

❑ **Yes** ❑ **No**

If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval: 12 months

Does the member meet the following criteria?

If requesting any of the following **PREFERRED** drugs: Byetta® ,Trulicity™ or Victoza® please check the diagnosis. No additional prior authorization criteria are required.

Does the member have a diagnosis of Type 2 Diabetes Mellitus? ❑ **Yes** ❑ **No**

If requesting any of the following **NON-PREFERRED** drugs: Bydureon™ BciseSQ, liraglutide, Mounjaro® , Ozempic®, Rybelsus®, Soliqua® 100/33, Tanzeum™, Xultophy® please complete all of the required prior authorization criteria.

1. Does the member have a diagnosis of Type 2 Diabetes Mellitus? ❑ **Yes** ❑ **No**

   If **Yes**, please provide the value of the lab that was performed within the **last 12 months** and has been used to confirm the member's diagnosis along with the date of the result **(A1c of greater than or equal to 6.5 is required for first starts)**:

   - **A1c Value:**_____ **Date:**_____

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2. Has the member tried and failed 2 different **PREFERRED** products? (If non-preferred product being requested) ❑ **Yes** ❑ **No**

   If **Yes**, please specify the drug, the length of the member's trial, and reason for discontinuation.

   Drug 1: _____

   Drug 2: _____

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****