

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	
<input type="checkbox"/> Victoza [®]	<input type="checkbox"/> Trulicity [™]
Non-Preferred Drugs	
*Require prior authorization and trial and failure of 2 (two) preferred drugs	
<input type="checkbox"/> Xultophy [®]	<input type="checkbox"/> exenatide (generic Byetta [®])
<input type="checkbox"/> liraglutide (generic Victoza [®])	<input type="checkbox"/> Mounjaro [®]
<input type="checkbox"/> Ozempic [®]	<input type="checkbox"/> Rybelsus [®]
<input type="checkbox"/> Soliqua [®] 100/33	<input type="checkbox"/> Tanzeum [™]

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 #: _____

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: _____

(Continued on next page)

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: Trulicity™ and 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: exenatide (generic Byetta®), liraglutide, Mounjaro®, Ozempic®, Rybelsus®, Soliqua® 100/33, Tanzeum™, Xultophy® please complete all the required prior authorization criteria.
 - 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: _____

- 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.****