

# SENTARA HEALTH PLANS

## 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.**

### Glucagon-like peptide (GLP-1) receptor agonists

**Drug Requested:** (select ONE of the following)

<input type="checkbox"/> <b>Bydureon BCise</b> <sup>®</sup> (exenatide ER)	<input type="checkbox"/> <b>Ozempic</b> <sup>®</sup> (semaglutide)
<input type="checkbox"/> <b>Byetta</b> <sup>®</sup> (exenatide ER)	<input type="checkbox"/> <b>Rybelsus</b> <sup>®</sup> (semaglutide)
<input type="checkbox"/> <b>Liraglutide</b> (Victoza <sup>®</sup> ABA)	<input type="checkbox"/> <b>Trulicity</b> <sup>®</sup> (dulaglutide)
<input type="checkbox"/> <b>Mounjaro</b> <sup>®</sup> (tirzepatide)	<input type="checkbox"/> <b>Victoza</b> <sup>®</sup> (liraglutide)

**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: \_\_\_\_\_

**Provider please note:** Requests received for any target drug above, prescribed solely for chronic weight management will be **DENIED** as these drugs have **NOT** been FDA approved for this indication.

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

Yes **OR**  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.

- Member has a diagnosis of Type 2 Diabetes Mellitus as confirmed by a history of **ONE** of the following **(submit documentation)**:
  - Hemoglobin A1c (A1C) greater than or equal to 6.5%
  - Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL (after fasting for at least 8 hours)
  - 2-hour plasma glucose greater than or equal to 200 mg/dL as part of an oral glucose tolerance test (75 g oral glucose after fasting for at least 8 hours)
- Member must meet **ONE** of the following:
  - Hemoglobin A1c (A1C) greater than or equal to 9%
  - Member has tried and failed, has a clinically significant contraindication or intolerance to metformin **(verified by chart notes and/or pharmacy paid claims)**
  - Member has atherosclerotic cardiovascular disease (ASCVD) as defined by one or more of the following conditions or past medical history **(check all that apply)**:
    - Acute coronary syndrome
    - Coronary artery disease (CAD)
    - History of myocardial infarction (MI)
    - Stable or unstable angina
    - History of coronary or other arterial revascularization
    - History of stroke
    - History of transient ischemic attack (TIA)
    - Peripheral arterial disease (PAD)
- Member has been established on requested drug for at least 90 days **AND** has demonstrated effectiveness via a lowered hemoglobin A1C (A1C) from baseline

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- **For Byetta, Bydureon BCise & Victoza Requests:** Member has tried and failed at least **30 days** of therapy with **TWO (2)** of the following:

<input type="checkbox"/> Mounjaro®	<input type="checkbox"/> Ozempic®
<input type="checkbox"/> Rybelsus®	<input type="checkbox"/> Trulicity®

*Not all drugs may be covered under every Plan.*

*If a drug is non-formulary on a Plan, documentation of medical necessity will be required.*

***\*\*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.\****