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)

❑ **Bydureon BCise®** (exenatide ER)	❑ **Rybelsus®** (semaglutide)
❑ **Byetta®** (exenatide ER)	❑ **Trulicity®** (dulaglutide)
❑ **Mounjaro®** (tirzepatide)	❑ **Victoza®** (liraglutide)
❑ **Ozempic®** (semaglutide)	

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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.

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.

(Continued on next page)

- ❑ Provider attests member has a diagnosis of Type 2 Diabetes Mellitus
- ❑ **For Byetta, Bydureon BCise & Victoza Requests:** Member has tried and failed at least **30 days** of therapy with **TWO (2)** of the following:

❑ Mounjaro®	❑ Ozempic®
❑ Rybelsus®	❑ 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.

***Approved by the Pharmacy and Therapeutics Committee:** ~~7/19/2012; 2/22/2017; 4/16/2020;~~ ~~7/21/2022;~~ **5/25/2023**
REVISED/UPDATED ~~9/28/2012; 7/17/2014; 7/22/2014; 9/26/2014; 10/7/2014; 10/8/2014; 11/5/2014; 3/19/2015; 4/29/2015; 5/27/2015; 12/29/2015; 12/20/2016; 2/22/2017; 3/20/2017; 8/18/2017; 9/14/2017; 6/25/2018; 1/28/2019; (Reformatted): 3/19/2019; 6/9/2020; 7/9/2022; 8/5/2022;~~ **11/6/2023**