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 covermymeds.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
   If yes, is the patient currently stable on the requested agent? ☐ Yes ☐ No
2. 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: 1) A1C greater than or equal to 6.5%, 2) fasting plasma glucose greater than or equal to 126 mg/dL, 3) 2-hour plasma glucose greater than or equal to 200 mg/dL during OGTT, or 4) random plasma glucose greater than or equal to 200 mg/dL, along with symptoms of hyperglycemia? **Please note, chart notes or a copy of lab test results confirming your diagnosis are required.** ☐ Yes ☐ No
3. Will the patient be using the requested agent in combination with a DPP-4 containing agent for the requested indication? ☐ Yes ☐ No
4. Will the patient be using the requested agent in combination with another GLP-1 receptor agonist agent? ☐ Yes ☐ No
5. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

_____

_____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For Adlyxin, Byetta, Liraglutide, and Victoza requests:

6. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
7. Has the patient tried and had an inadequate response to semaglutide (Ozempic OR Rybelsus)? ☐ Yes ☐ No

   If no, please answer the following:

   - Was semaglutide (Ozempic OR Rybelsus) 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 contraindication: _____

     _____
   - 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
8. Has the patient tried and had an inadequate response to dulaglutide (Trulicity)? ☐ Yes ☐ No

   If no, please answer the following:

   - Was dulaglutide (Trulicity) 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 contraindication: _____

     _____
   - 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

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

9. Has the patient tried and had an inadequate response to tirzepatide (Mounjaro)? ☐ Yes ☐ No

If no, please answer the following:

- Was tirzepatide (Mounjaro) 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 contraindication: _____
  _____
- 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

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
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525