Prior Authorization Request Form for Hypoglycemics, Incretin Mimetics/Enhancers

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. **For requests for SYMLIN (pramlintide),** submit chart documentation supporting the use of Symlin.
2. **For a NON-PREFERRED DPP-4 INHIBITOR:**

   ☐Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 INHIBITORS that are approved or medically accepted for the member's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.)*
3. **For a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST:**

   ☐The member is being treated for or has a diagnosis of DIABETES

   ☐The member is being treated for OVERWEIGHT or OBESITY and:

   ☐**Attestation from the prescriber:**

   ☐The member was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

   ☐**The member is 18 years of age or older and:**

   Pre-treatment weight: _____ Pre-treatment BMI: _____

   ☐Has a BMI greater than or equal to 30 kg/m^2

☐ Has a BMI greater than or equal 27 kg/m^2 and less than 30 kg/m^2 AND at least one of the following weight-related comorbidities:

- ☐ cardiovascular disease
- ☐ dyslipidemia
- ☐ hypertension
- ☐ metabolic syndrome
- ☐ obstructive sleep apnea
- ☐ prediabetes
- ☐ type 2 diabetes
- ☐ other (list): _____

☐ Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for member's ethnicity, etc. AND has at least one of the following weight-related comorbidities:

- ☐ cardiovascular disease
- ☐ dyslipidemia
- ☐ hypertension
- ☐ metabolic syndrome
- ☐ obstructive sleep apnea
- ☐ prediabetes
- ☐ type 2 diabetes
- ☐ other (list): _____

☐ **The member is <u>less than 18 years of age</u> and:**

Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

☐ Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

☐ **For a <u>NON-PREFERRED Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST</u>** (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist.*)**<u>:</u>**

☐ **For the treatment of OVERWEIGHT OR OBESITY:**

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:

- ☐ Ozempic
- ☐ Trulicity
- ☐ Victoza

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:

- ☐ Saxenda
- ☐ Wegovy
- ☐ Zepbound

☐ **For the treatment of ALL OTHER diagnoses:**

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:

- ☐ Ozempic
- ☐ Trulicity
- ☐ Victoza

RENEWAL requests

Prior Authorization Request Form for Hypoglycemics, Incretin Mimetics/Enhancers

☐ **For a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:**

☐ **The member is 18 years of age or older:**

Pre-treatment weight: _____ Current weight: _____

☐ **The member is less than 18 years of age:**

Pre-treatment BMI: _____ Current BMI: _____

Pre-treatment BMI z-score: _____ Current BMI z-score: _____

☐ At least **one** of the following:

- ☐ The dose of the requested medication is currently being titrated
- ☐ The member experienced a percent reduction in body weight (for beneficiaries 18 years of age or older) or BMI or BMI z-score (for beneficiaries less than 18 years of age) that is consistent with the recommended cutoff in the FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose
- ☐ The member experienced an improvement in degree of adiposity or waist circumference from baseline
- ☐ The member experienced clinical benefit with the requested medication in at least one weight-related comorbidity from baseline, such as dyslipidemia, hypertension, type 2 diabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.

☐ **Attestation from the prescriber:**

- ☐ The member was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐ **Request is for a NON-PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)***:**

- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:
  - ☐ Ozempic
  - ☐ Trulicity
  - ☐ Victoza
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:
  - ☐ Saxenda
  - ☐ Wegovy
  - ☐ Zepbound

☐ **The member is being treated for a diagnosis OTHER THAN OVERWEIGHT OR OBESITY or the request is for a DPP-4 INHIBITOR or SYMLIN (pramlintide).**

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO (844) 205-3386

Prescriber Signature:	**Date**:

PA Department will respond via fax or phone within 24 hours. Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate.