Clinical Policy: Hypoglycemics, Incretin Mimetics/Enhancers

Reference Number: PHW.PDL.111
Effective Date: 01/01/2020
Last Review Date: 10/2022

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Incretin Mimetic/Enhancer Hypoglycemis are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Hypoglycemics, Incretin Mimetics/Enhancers

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, Incretin Mimetics/Enhancers that meet any of the following conditions must be prior authorized:

1. A non-preferred Hypoglycemic, Incretin Mimetic/Enhancer.

2. A Hypoglycemic, Incretin Mimetic/Enhancer with a prescribed quantity that exceeds the quantity limit.

3. A glucagon-like peptide-1 (GLP-1) receptor agonist when there is a record of a recent paid claim for another GLP-1 receptor agonist or a dipeptidyl peptidase 4 (DPP-4) inhibitor (therapeutic duplication).

4. A DPP-4 inhibitor when there is a record of a recent paid claim for another DPP-4 inhibitor or a GLP-1 receptor agonist (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Hypoglycemics, Incretin Mimetic/Enhancer, has a history of therapeutic failure of or a contraindication or an intolerance of the preferred Hypoglycemics, Incretin Mimetics/Enhancers with the same mechanism of action approved or medically accepted for the beneficiary's diagnosis,

AND

2. For therapeutic duplication of a GLP-1 receptor agonist or a DPP-4 inhibitor, **one** of the following:

   a. Is being transitioned to or from another GLP-1 receptor agonist or a DPP-4 inhibitor with the intent of discontinuing one of the medications,
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines;

   AND

3. If a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer. If the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the applicable guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. **Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2023: policy revised according to DHS revisions effective 01/09/2023	10/2022