Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antihyperglycemics, Incretin Mimetic (GLP-1 Receptor Agonist)
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antihyperglycemics, Incretin Mimetic (GLP-1 Receptor Agonist)** for **Commercial, MD Medicaid,** and **FEHB (Federal)** plans**.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

Medications:

• BYDUREON BCISE AUIJ • TRULICITY SOPN • VICTOZA • OZEMPIC	• RYBELSUS • SOLIQUA • XULTOPHY

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Does the member have a diagnosis of type 2 diabetes mellitus?
   □ No □ Yes

2. Is the HbA1c within 2% above goal (as per ADA guidelines) within 90 days of the PA request (*Note: if A1c is >2% above goal, insulin therapy is recommended)*?
   □ No □ Yes

3. Is the member on another GLP-1 agonist or any agent within the DPP-4 inhibitor drug class?
   □ No □ Yes

4. Is the member using for chronic weight loss management (CWM)?
   □ No □ Yes

5. **If member has <u>diagnosis of ASCVD</u> or <u>indicators of high ASCVD risk</u> [conditions include: acute coronary syndromes (ACS), history of myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, ischemic stroke, transient ischemic attack (TIA) or symptomatic peripheral arterial disease (PAD)]:**
   - Has the member failed adequate trial (90 days) or metformin and Jardiance at maximum tolerated dose unless resulting in a therapeutic failure, intolerance, or contraindication?
     □ No □ Yes

6. **If member <u>does NOT</u> have diagnosis of ASCVD or indicators of high ASCVD risk:**
   - Has the member failed adequate trial (90 days) of ALL of the following medications for diabetes, unless allergy or intolerance*?
     - Metformin
     - Sulfonylurea
     - Pioglitazone (if BMI <35)
     - Jardiance
     - Tradjenta
     - Insulin glargine or insulin glargine-yfgn (if A1c >2% above goal)

     □ No □ Yes

*This includes recurrent hypoglycemia on insulin therapy despite dose adjustments by provider or healthcare team

Additional Questions for Ozempic:

7. Does the member have a documented trial, intolerance or contraindication to Victoza*PA?
   □ No □ Yes

Additional Questions for Trulicity, Bydureon and Rybelsus:

8. Does the member have a documented trial, intolerance or contraindication to both Victoza*PA and Ozempic*PA?
   □ No □ Yes

Additional Questions for Soliqua or Xultophy:

9. Does the member have a documented trial, intolerance, or contraindication to both Victoza*PA and Ozempic*PA?
   □ No □ Yes

10. Does the member have clinical need for use of the combination product over separate agents?
    □ No □ Yes

*PA *This medication is also subject to PA review*

For continuation of therapy, please respond to <u>additional questions</u> below.

1. Is the member using for CWM?
   □ No □ Yes

2. Has the patient failed adequate trial (90 days), has intolerance, or contraindication to Victoza*PA?
   □ No □ Yes

3. If no diagnosis of ASCVD or indicators of high ASCVD risk, does the patient have documented A1C lowering of 0.5% from initial or A1C now at goal?
   □ No □ Yes □ N/A – patient has diagnosis of ASCVD or indicators of high ASCVD risk

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**