Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antihyperglycemic – Incretin Mimetics Combination (Mounjaro)
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 4 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antihyperglycemic – Incretin Mimetics Combination (Mounjaro)** for **Commercial** 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

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 start date: _____

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

Clinical Criteria:

1. Diagnosis of type 2 diabetes mellitus,
   □ No □ Yes

2. **AND** on maximally tolerated metformin dose (2000 mg) for at least 3 months or allergy/intolerance to metformin documented,
   □ No □ Yes

3. **AND** patient is not using for chronic weight management (CWM),
   □ No □ Yes

4. **AND** patient is not on any agent in any of the following drug classes: GLP-1 agonists or DPP-4 inhibitors,
   □ No □ Yes

5. **AND** A1c within 2% of goal (as per ADA guidelines) in the past 3 months, and previously failed adequate trial (≥3 months), experienced intolerance or contraindication to ALL of the following agents or associated combination products:
   - Glipizide
   - Pioglitazone (if BMI <35)
   - Tradjenta
   - Jardiance
   - At least TWO of the following KP-preferred GLP-1 agonists: Victoza, Ozempic, OR Rybelsus

   □ No □ Yes

6. **OR** A1c ≥2% above goal (as per ADA guidelines) in the past 3 months and recurrent hypoglycemia on insulin therapy despite dose adjustments, and previously failed adequate trial (≥3 months), experienced intolerance or contraindication to insulin glargine or insulin glargine-yfgn, Tradjenta, Jardiance, and at least TWO of the KP-preferred GLP-1 agonists listed above
   □ No □ Yes

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

1. Has the patient failed adequate trial (≥3 months), or has intolerance or contraindication to BOTH Victoza and Ozempic?
   □ No □ Yes

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

2. Does the patient have documented A1c lowering of at least 0.5% from initial or A1c now at goal?
   □ No □ Yes

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:**