# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

## Glucagon-like peptide (GLP-1) receptor agonists

**Drug Requested:** (select **ONE** of the following)

| | |
|---|---|
| ❑ **Bydureon BCise®** (exenatide ER) | ❑ **Ozempic®** (semaglutide) |
| ❑ **Byetta®** (exenatide ER) | ❑ **Rybelsus®** (semaglutide) |
| ❑ **Liraglutide** (generic Victoza®) | ❑ **Trulicity®** (dulaglutide) |
| ❑ **Mounjaro®** (tirzepatide) | |

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member AvMed #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

**Provider please note: Requests received for any target drug above, prescribed solely for chronic weight management will be DENIED as these drugs have NOT been FDA approved for this indication.**

**(Continued on next page)**

- Will the member be discontinuing a previously prescribed glucagon-like peptide (GLP-1) receptor agonist medication if approved for requested medication?

  ❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  **Medication to be discontinued:** _____ **Effective date:** _____

  **Medication to be initiated:** _____ **Effective date:** _____

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has a diagnosis of Type 2 Diabetes Mellitus as confirmed by a history of **ONE** of the following **(submit documentation)**:
  - ❑ Hemoglobin A1c (A1C) greater than or equal to 6.5%
  - ❑ Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL (after fasting for at least 8 hours)
  - ❑ 2-hour plasma glucose greater than or equal to 200 mg/dL as part of an oral glucose tolerance test (75 g oral glucose after fasting for at least 8 hours)
- ❑ Member must meet **ONE** of the following:
  - ❑ Hemoglobin A1c (A1C) greater than or equal to 9%
  - ❑ Member has tried and failed, has a clinically significant contraindication or intolerance to metformin **(verified by chart notes and/or pharmacy paid claims)**
  - ❑ Member has atherosclerotic cardiovascular disease (ASCVD) as defined by one or more of the following conditions or past medical history **(check all that apply)**:
    - ❑ Acute coronary syndrome
    - ❑ Coronary artery disease (CAD)
    - ❑ History of myocardial infarction (MI)
    - ❑ Stable or unstable angina
    - ❑ History of coronary or other arterial revascularization
    - ❑ History of stroke
    - ❑ History of transient ischemic attack (TIA)
    - ❑ Peripheral arterial disease (PAD)
  - ❑ Member has been established on requested drug for at least 90 days **AND** has demonstrated effectiveness via a lowered hemoglobin A1C (A1C) from baseline

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- ❑ **For Byetta, Bydureon BCise & liraglutide (generic Victoza®) Requests:** Member has tried and failed at least **30 days** of therapy with **TWO (2)** of the following:

| | |
|---|---|
| ❑ Mounjaro® | ❑ Ozempic® |
| ❑ Rybelsus® | ❑ Trulicity® |

***Not all drugs may be covered under every Plan.***

***If a drug is non-formulary on a Plan, documentation of medical necessity will be required.***

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.**