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** (Victoza® ABA)	❑ **Trulicity®** (dulaglutide)
❑ **Mounjaro®** (tirzepatide)	❑ **Victoza®** (liraglutide)

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.

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- 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 & 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.*

***Approved by the Pharmacy and Therapeutics Committee:** ~~7/19/2012; 2/22/2017; 4/16/2020; 7/21/2022; 5/25/2023;~~ **7/25/2024**
REVISED/UPDATED/REFORMATTED: ~~9/28/2012; 7/17/2014; 7/22/2014; 9/26/2014; 10/7/2014; 10/8/2014; 11/5/2014; 3/19/2015; 4/29/2015; 5/27/2015; 12/29/2015; 12/20/2016; 2/22/2017; 3/20/2017; 8/18/2017; 9/14/2017; 6/25/2018; 1/28/2019; 3/19/2019; 6/9/2020; 7/9/2022; 8/5/2022; 11/6/2023;~~ **8/21/2024**