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)	❑ **Rybelsus®** (semaglutide)
❑ **Byetta®** (exenatide ER)	❑ **Trulicity®** (dulaglutide)
❑ **Mounjaro®** (tirzepatide)	❑ **Victoza®** (liraglutide)
❑ **Ozempic®** (semaglutide)	

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 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.

❑ Provider attests member has a diagnosis of Type 2 Diabetes Mellitus

❑ **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**
REVISED/UPDATED ~~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; (Reformatted): 3/19/2019; 6/9/2020; 7/9/2022; 8/5/2022; 11/6/2023;~~ **7/01/2024**