HIGHMARK HEALTH OPTIONS

Updated: 04/2026
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Request for Prior Authorization for GLP-1 Receptor Agonist
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for GLP-1 Receptor Agonist require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

GLP-1 Receptor Agonist Prior Authorization Criteria:

For all requests the following criteria must be met in addition to the diagnosis specific criteria below:

- For non-preferred agents, must have a therapeutic failure, contraindication, or intolerance to the preferred agent(s) approved or medically accepted for the member's diagnosis.
- Is prescribed for an FDA-approved or medically accepted indication.
- The requested dose and frequency are in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines.

Coverage may be provided with a diagnosis of **type 2 diabetes** OR **chronic kidney disease, stage 3a or above**

- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, resubmission will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
    - Documentation the member has been on a glp-1 receptor agonist within the last forty-five days.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided **to reduce the risk of major adverse cardiovascular events (MACE)** when the following criteria is met:

- Must have a BMI ≥ 27 $kg/m^{2.}$
- Must have established cardiovascular disease- one of the following:
  - Post Myocardial Infarction
  - Post Stroke
  - Peripheral Vascular Disease is also known as peripheral arterial disease and at least one of the following:
    - Intermittent claudication with ankle-brachial index less than 0.85 (at rest),
    - A history of peripheral arterial revascularization procedure or peripheral vascular angioplasty (without implant or graft)
    - A history of amputation due to atherosclerotic disease
  - Hypertension
  - Hyperlipidemia
  - Heart Failure
- **Initial Duration of Approval:** 6 months

- **Reauthorization Criteria:**
- Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service and does **not** require resubmission of initial coverage documentation. Claims will automatically adjudicate at point of sale, without a requirement to submit for reauthorization, when the member has claims history of a glp-1 receptor agonist within the last forty-five days.
- If there is no paid claim in the last forty-five days, continued coverage may be approved when the prescriber attests that the member:
    - Continues to derive clinical benefit, and
    - Requires ongoing therapy as part of their treatment plan.
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided for a diagnosis of **moderate to severe obstructive sleep apnea (OSA)** when the following criteria are met:

- Must be 18 years of age or older.
- Must have chart documentation of all the following:
    - Body Mass index (BMI) BMI $\geq$ 27 kg/m^2
    - Diagnosis of moderate to severe OSA confirmed via baseline polysomnography confirming disease severity with an apnea-hypopnea index (AHI) $\geq$ 15 events/hour without use of positive airway pressure (PAP)
- Must have tried dietary and lifestyle modifications for weight loss.
- **Initial Duration of Approval:** 6 months
- **Reauthorization Criteria:**
    - Must be used in combination with a reduced calorie diet and increased physical activity.
    - Must meet ONE of the following (chart documentation required):
        - If member has been using the GLP-1 receptor agonist for less than 6 months, documentation of lifestyle changes and behavior modifications (e.g., healthy diet and increased physical activity) must be supplied at the time of the reauthorization request
        - If member has been using the GLP-1 receptor agonist for greater than or equal to 6 months, one of the following:
            - If initial dose titration has been completed, the member has been using the GLP-1 receptor for at least 3 consecutive months at the maximum tolerated dose, and the member has 5% total weight loss as well as documentation of dietary changes
            - If initial dose titration has not been completed and the member has been using the GLP-1 receptor for less than 3 consecutive months at the maximum tolerated dose, and member has documentation of dietary changes, may be approved up to a 3-month trial of the requested GLP-1 receptor agonist at maximum tolerated dose.
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided with a diagnosis of **noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH)** and all the following criteria is met:

- Must be prescribed by or in consultation with a hepatologist or gastroenterologist
- Documentation of a confirmed diagnosis of MASH with fibrosis stage 2 or 3 confirmed by **one** of the following within the last 6 months:

    - Liver biopsy confirming steatosis OR
        - One of the following assessments:
        - imaging-based assessment (e.g., FibroScan)
        - magnetic resonance-based elastography (MRE),
        - magnetic resonance imaging–proton density fat fraction (MRI-PDFF)
- For a request for a product NOT containing a GLP-1 receptor for the diagnosis of MASH, please refer to policy CP-206.382-MD-DE Noncirrhotic metabolic dysfunction associated steatohepatitis (MASH).
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
    - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service and does **not** require resubmission of initial coverage documentation. Claims will automatically adjudicate at point of sale, without a requirement to submit for reauthorization, when the member has claims history of a glp-1 receptor agonist within the last forty-five days.
    - If there is no paid claim in the last forty-five days, continued coverage may be approved when the prescriber attests that the member:
        - Continues to derive clinical benefit, and
        - Requires ongoing therapy as part of their treatment plan.
- **Reauthorization Duration of Approval**: 12 months

Coverage may be provided the indication of **weight loss** when the following criteria is met:

- Adult Body Mass Index (BMI) of thirty or higher OR has a BMI between ≥ 27 kg/m2 and < 30 kg/m2 and have at least one (1) co-morbid condition listed above
- Pediatric BMI ≥ 95th percentile for age and weight
- **Initial Duration of Approval:** 6 months
- **Reauthorization Criteria:**
    - Documentation of member's current weight since initiating therapy.
    - Adult must lose at least 5% of their initial starting weight
        - If the member fails to maintain at least a 5% weight reduction from baseline, the request will be denied.
    - Pediatric must lose ≥ 4% of the initial starting weight
        - If the member fails to maintain at least a 4% weight reduction from baseline, the request will be denied.
    - Must continue to implement diet and exercise into their weight loss plan.
- **Reauthorization Duration of Approval:** 6 months

For any other FDA-approved or medically accepted diagnoses (excluding treatment of overweight or obesity), both of the following:

- Has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines
- The requested drug will be used in combination with optimized pharmacotherapy for the condition being treated based on current consensus guidelines unless contraindicated or not tolerated

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

REFERENCES:

1. Samson, S., Vellanki P., Blonde, L. et al. Statement: AACE Comprehensive Type 2 Diabetes Management Algorithm – 2023 Update. May 2023. AACE Consensus Statement. 29(5); P305-340.
2. Victoza (liraglutide) [package insert]. Plainsboro, NJ: Novo Nordisk. October 2025.
3. Ozempic (semaglutide) [package insert]. Plainsboro, NJ: Novo Nordisk. October 2025.
4. Trulicity (dulaglutide) [package insert]. Indianapolis, IN: Eli Lilly and Company. June 2025.
5. Bydureon (exenatide) [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals. May 2025.
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17. Clinicaltrials.gov. A Phase 3 Study to Evaluate the Efficacy and Safety of MGL-3196 (Resmetirom) in Patients With NASH and Fibrosis (MAESTRO-NASH). Published 2019. https://clinicaltrials.gov/study/NCT03900429.
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GLP-1 RECEPTOR AGONISTS

PRIOR AUTHORIZATION FORM (page 1 of 2)

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8:00 am to 7:00 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

What is the BMI? ☐ < 27 ☐ 27-29 ☐ 30 or greater

Is the member actively involved in a dietary/behavior modification program for weight loss? ☐ Yes ☐ No

Is the member actively following a fitness exercise regimen? ☐ Yes ☐ No

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GLP-1 RECEPTOR AGONISTS

PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

MEDICAL HISTORY (Continued -Complete for ALL requests)

Does the member have Type 2 **Diabetes Mellitus?** ☐ Yes ☐ No

Does the member have a diagnosis of **Chronic Kidney Disease, Stage 3a or above**? ☐ Yes ☐ No

For reduction of risk of **MACE**, is the member being treated for cardiovascular disease? ☐ Yes (list conditions(s) below) ☐ No

For treatment of **Obstructive Sleep Apnea (OSA)**, what is baseline AHI (without PAP)? ☐ < 15 events/hr ☐ >/= 15 events/hr

For treatment of **MASH**, what is the members liver fibrosis score: _____

How was the diagnosis confirmed (check all that apply-**submit chart documentation**)?

☐ Liver biopsy confirming steatosis

☐ imaging-based assessment (e.g., Fibro Scan,

☐ magnetic resonance-based elastography [MRE],

☐ magnetic resonance imaging–proton density fat fraction [MRI-PDFF]

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Does the member have Type 2 **Diabetes Mellitus?** ☐ Yes ☐ No

Is this ongoing therapy for the member (the member has been on a glp-1 receptor agonist within the last 45 days)? ☐ Yes ☐ No

Does the member have a diagnosis of **Chronic Kidney Disease, Stage 3a or above**? ☐ Yes ☐ No

For treatment of **OSA**: Baseline weight: _____ Date: _____ Current weight: _____ Date: _____

Is the member actively involved in a dietary/behavior modification program for weight loss? ☐ Yes ☐ No

For treatment of **MACE or MASH**, the member has received a clinical benefit demonstrated by either (select all that apply):

Is this ongoing therapy for the member (the member has been on a glp-1 receptor agonist within the last 45 days)? ☐ Yes ☐ No

For **obesity,** Baseline weight: _____ Date: _____ Current weight: _____ Date: _____

Is the member actively involved in a dietary/behavior modification program for weight loss? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date