HIGHMARK HEALTH OPTIONS

Updated: 01/2026
DMMA Approved: 11/2025

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.

Note: GLP-1 Receptor Agonists are not covered for the treatment of overweight or obesity. GLP-1 Receptor Agonists may be covered for the treatment of diagnoses that are indicated in the FDA-approved package labeling or other medically accepted indications excluding treatment of overweight or obesity.

******* For a request for a drug containing a glucagon-like peptide-1 (GLP-1) receptor agonist for the diagnosis of Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH), please refer to policy CP-206.382-MD-DE Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH) Agents *******

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
    - *Therapeutic failure of a GLP-1 Receptor Agonist is defined as follows:* Failure to achieve positive clinical outcome(s) defined in the reauthorization guidelines below while utilizing the maximum FDA-approved dose of the GLP-1 Receptor Agonist with documentation of adherence to the GLP-1 Receptor Agonist in combination with lifestyle changes and behavioral modifications (e.g., healthy diet and increased physical activity). If the member is not at the maximum FDA-approved dose of the GLP-1 Receptor Agonist due to intolerance, must submit chart documentation that the following approaches were tried over a period of at least one month: dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist), prescription antiemetics, and, for beneficiaries who tolerated lower doses of the GLP-1 Receptor Agonist, dose adjustment to remediate the side effects experienced with higher doses of the GLP-1 Receptor Agonist.
    - *For a request to change from one GLP-1 Receptor Agonist (e.g., a semaglutide product) to a different GLP-1 Receptor Agonist (e.g., a tirzepatide product) due to intolerance:* Must submit chart documentation that the following approaches were tried over a period of at least one month: dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist), prescription antiemetics, and, for members who tolerated lower doses of the GLP-1 Receptor Agonist, dose adjustment to remediate side effects experienced with higher doses of the GLP-1 Receptor Agonist.
- Is prescribed for an FDA-approved or medically accepted indication
- The requested dose and frequency is 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** and the following criteria is met:

- Documentation of failure of ≥ 3 consecutive months of metformin or a metformin combination product as evidenced by HbA1c ≥ 7%, unless the member meets at least one of the following:
  - Metformin is contraindicated or clinically significant adverse effects are experienced.
  - The member has an AIC>7.5% and the requested medication will be used in combination with another agent (Documentation of complete regimen must be provided)
- **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, documentation 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 45 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 be 45 years of age or older
- Must have a Z68.27 BMI ≥ 27 kg/m^2
- Must have established cardiovascular disease- one of the following (please note the required ICD10 codes):
  - I25.2 post myocardial infarction
  - Z86.73 post stroke
  - I73.9 peripheral vascular disease also known as peripheral arterial disease and at least one of the following:
    - Intermittent claudication (I70.21) with ankle-brachial index less than 0.85 (at rest),
    - Z95.82 A history of peripheral arterial revascularization procedure or Z98.62 Peripheral vascular angioplasty status (without implant or graft),
    - Z89 along with I70.26 A history of amputation due to atherosclerotic disease
- Must be on optimized pharmacotherapy to be used in combination with requested drug for established cardiovascular disease based on current consensus guidelines unless contraindicated or not tolerated (e.g. lipid-lowering medication, platelet-aggregation inhibitors, beta-blockers, ACE inhibitors, ARBs).
- Must be used in combination with a reduced calorie diet and increased physical activity.
- **Initial Duration of Approval:** 6 months

- **Reauthorization Criteria:**
  - Must be on optimized pharmacotherapy to be used in combination with requested drug for established cardiovascular disease based on current consensus guidelines unless contraindicated or not tolerated (e.g. lipid-lowering medication, platelet-aggregation inhibitors, beta-blockers, ACE inhibitors, ARBs).
  - Must be used in combination with a dietary/behavior modification program (e.g. reduced calorie diet and increased physical activity)
- **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 of the following:
  - Body Mass index (BMI) BMI $\geq$ 27 kg/m^2
  - Diagnosis of moderate to severe OSA confirmed in the last 2 years according to one of the following:
    - Must have baseline polysomnography confirming disease severity with an apnea-hypopnea index (AHI) $\geq$ 15 events/hour without use of positive airway pressure (PAP)
      AND/OR
    - The most recent consensus treatment guidelines (e.g. American Academy of sleep Medicine International Classification of Sleep disorders)
  - Utilization of positive airway pressure (PAP) with documented adherence to PAP treatment (defined as use of a PAP device for greater than or equal to four hours per night on 70% of nights during a consecutive 30-day period), or, if the beneficiary has a medical reason PAP cannot be used, utilization of or intolerance to an oral appliance for OSA
- Must have tried dietary and lifestyle modifications for weight loss
- Must have a 6 month trial of and plan to continue dietary/behavior modification program (e.g. healthy diet, increased physical activity) or a medical reason why immediate treatment is necessary.
- **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):
    - Member has been using the GLP-1 receptor agonist for less than 6 months and has documentation of lifestyle changes and behavior modifications (e.g. healthy diet and increased physical activity)
    - 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 and the member has been using the GLP-1 receptor for at least 3 consecutive months at the maximum tolerated dose, has 5% total body weight loss and documentation of dietary changes

- If initial dose titration has not been completed and the member has been using the GLP-1 receptor for at less than 3 consecutive months at the maximum tolerated dose, and member has documentation of dietary changes, may be approved up to 3 month trial of the requested GLP-1 receptor agonist at maximum tolerated dose.
  - Must have and maintain at least a 25% reduction in AHI compared to baseline as documented via either sleep study or device report
  - Utilization of PAP with documented adherence to PAP treatment (defined as use of PAP devices for four or more hours per night on 70% of nights during a consecutive 30-day period) unless PAP is no longer recommended, or, if the beneficiary has a medical reason PAP cannot be used, utilization of or intolerance to an oral appliance for OSA
- **Reauthorization Duration of Approval:** 6 months (3 months for members using less 3 months of consecutive use)

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.
6. Byetta (exenatide) [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals. May 2025.

7. Mounjaro (tirzepatide) Indianapolis, IN: Eli Lilly and Company. September 2025.
8. Rybelsus (semaglutide) [package insert]. Plainsboro, NJ: Novo Nordisk. December 2024.
9. Soliqua (insulin glargine/lixisenatide) [package insert]. Sanofi. July 2025.
10. Xultophy (insulin degludec/liraglutide) [package insert]. Plainsboro, NJ: Novo Nordisk. October 2025.
11. Wegovy [package insert]. Plainsboro, NJ: Novo Nordisk. October 2025.
12. Zepbound [package insert]. Indianapolis, IN: Eli Lilly and Company. September 2025.
13. Saxenda (liraglutide) [package insert]. Plainsboro, NJ: Novo Nordisk. October 2025.

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GLP-1 RECEPTOR AGONISTS PRIOR AUTHORIZATION FORM

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
For Diabetes, Has the member tried an antidiabetic medication (other than metformin or a metformin combination product) for ≥ 3 consecutive months? ☐ Yes ☐ No Please provide the member's HbA1C while on antidiabetic therapy? _____
For reduction of risk of MACE, is the member being treated for cardiovascular disease? ☐ Yes (list med(s) below) ☐ No
For treatment of Obstructive Sleep Apnea (OSA), what is baseline AHI (without PAP)? ☐ < 15 events/hr ☐ >/= 15 events/hr

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Is the member continuing to include diet and exercise? ☐ Yes ☐ No
For diabetes, 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 reduction of risk of MACE, is the member on optimized pharmacotherapy to be used in combination with requested drug for established cardiovascular disease based on current consensus guidelines unless contraindicated or not tolerated? ☐ Yes ☐ No
For treatment of OSA: Baseline AHI: _____ events/hr, date: _____ Current AHI: _____events/hr, date: _____
Baseline weight: Date: Current weight: Date:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date