HIGHMARK HEALTH OPTIONS

Updated: 04/2024
DMMA Approved: 04/2024

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 for GLP-1 agonists for weight loss or to reduce cardiovascular risk in adults who are overweight or obese please refer to policy CP-206.219-MD-DE Anti-Obesity 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
- 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

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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:

Has the member tried metformin or a metformin combination product for ≥ 3 consecutive months? ☐ Yes ☐ No

Please provide the member's HbA1C while on metformin therapy? _____

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date