Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Hypoglycemics, Incretin Mimetics/Enhancers

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, Incretin Mimetics/Enhancers that meet any of the following conditions must be prior authorized:

1. A non-preferred Hypoglycemic, Incretin Mimetic/Enhancer. See the Preferred Drug List (PDL) for the list of preferred Hypoglycemics, Incretin Mimetic/Enhancers at: https://papdl.com/preferred-drug-list.

2. A glucagon-like peptide-1 (GLP-1) receptor agonist when there is a record of a recent paid claim for another GLP-1 receptor agonist or a dipeptidyl peptidase 4 (DPP-4) inhibitor in the Point-of-Sale Online Claims Adjudication System (therapeutic duplication).

3. A DPP-4 inhibitor when there is a record of a recent paid claim for another DPP-4 inhibitor or a GLP-1 receptor agonist in the Point-of-Sale Online Claims Adjudication System (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Hypoglycemic, Incretin Mimetic/Enhancer, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Hypoglycemic, Incretin Mimetic/Enhancer GLP-1 receptor agonist, **one** of the following:

   a. For a diagnosis of obesity, **all** of the following:

      i. For beneficiaries 18 years of age and older, **one** of the following:

         a) Has a body mass index (BMI) greater than or equal to 30 kg/m^2

         b) **Both** of the following:

            (i) **One** of the following:
               a. Has a BMI greater than or equal to 27 kg/m^2 and less than 30 kg/m^2
               b. Has been determined by the prescriber to be a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for the beneficiary's ethnicity, etc.

            (ii) Has at least one weight-related comorbidity as determined by the prescriber, such as dyslipidemia, hypertension, type 2 diabetes, prediabetes, obstructive sleep apnea, metabolic syndrome, etc.,

      ii. For beneficiaries less than 18 years of age, has a BMI in the 95th percentile or greater standardized for age and sex based on current Centers for Disease Control and Prevention charts,

      iii. Has been counseled about lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity),

iv. Is age- and weight-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

v. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

vi. Does not have a contraindication to the prescribed medication,

vii. Has history of therapeutic failure of or a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide PDL approved or medically accepted for the beneficiary's diagnosis or indication

b. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemic, Incretin Mimetic/Enhancer GLP-1 receptor agonists approved or medically accepted for the beneficiary's diagnosis; **AND**

2. For all other non-preferred Hypoglycemics, Incretin Mimetics/Enhancers, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers with the same mechanism of action approved or medically accepted for the beneficiary's diagnosis; **AND**

3. For therapeutic duplication of a GLP-1 receptor agonist or a DPP-4 inhibitor, **one** of the following:

   a. Is being transitioned to or from another GLP-1 receptor agonist or DPP-4 inhibitor with the intent of discontinuing one of the medications
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR A NON-PREFERRED HYPOGLYCEMIC, INCRETIN MIMETIC/ENHANCER GLP-1 RECEPTOR AGONIST FOR A DIAGNOSIS OF OBESITY: The determination of medical necessity of a request for renewal of a prior authorization for a non-preferred Hypoglycemic, Incretin Mimetic/Enhancer GLP-1 receptor agonist for a diagnosis of obesity that was previously approved will take into account whether the beneficiary:

1. For beneficiaries 18 years of age and older, **one** of the following:

   a. Is continuing with dose titration,
   b. Experienced a percent reduction of baseline body weight that is consistent with the recommended cutoff in FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose,
   c. Continues to experience clinical benefit from the GLP-1 receptor agonist based on the prescriber's assessment;

   AND

2. For beneficiaries less than 18 years of age, **one** of the following:

   a. Is continuing with dose titration,
   b. Experienced a percent reduction of baseline BMI or BMI z-score that is consistent with the recommended cutoff in FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose,
   c. Continues to experience clinical benefit from the GLP-1 receptor agonist based on the prescriber's assessment;

   AND

3. Has been counseled about lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity); **AND**

4. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

5. Does not have a contraindication to the prescribed medication; **AND**

6. Has history of therapeutic failure of or a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide PDL approved or medically accepted for the beneficiary's diagnosis or indication; **AND**

7. For therapeutic duplication of a GLP-1 receptor agonist, one of the following:

   a. Is being transitioned to or from another GLP-1 receptor agonist or DPP-4 inhibitor with the intent of discontinuing one of the medications
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Hypoglycemic, Incretin Mimetic/Enhancer. If the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the applicable guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

For a diagnosis of obesity, all requests will be approved for up to 6 months.

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone :		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request. *Check all that apply and submit documentation for each item.*

INITIAL requests

1. For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:

☐Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.)*

☐**Attestation from the prescriber:**

☐The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐**The beneficiary is 18 years of age or older:**

Pre-treatment weight: _____ Pre-treatment BMI: _____

☐Has a BMI greater than or equal to 30 kg/m^2

☐Has a BMI greater than or equal 27 kg/m^2 and less than 30 kg/m^2 and at least one of the following weight-related comorbidities:

☐dyslipidemia ☐obstructive sleep apnea
☐hypertension ☐prediabetes
☐metabolic syndrome ☐type 2 diabetes
☐other (list): _____ _____

☐Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for beneficiary's ethnicity, etc. and has at least one of the following weight-related comorbidities:

☐dyslipidemia ☐obstructive sleep apnea
☐hypertension ☐prediabetes
☐metabolic syndrome ☐type 2 diabetes
☐other (list): _____ _____

☐**The beneficiary is less than 18 years of age:**

Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

☐Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

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2. For the treatment of ALL OTHER diagnoses:

☐ **Request is for a non-preferred GLP-1 receptor agonist:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists that are approved or medically accepted for the beneficiary's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers GLP-1 receptor agonists.)*

☐ **Request is for a non-preferred DPP-4 inhibitor:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors that are approved or medically accepted for the beneficiary's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.)*

☐ **Request is for non-preferred Symlin (pramlintide)**

RENEWAL requests

☐ **For a non-preferred GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred GLP-1 receptor agonists on the Statewide Preferred Drug List that are approved or medically accepted for the beneficiary's diagnosis or indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred GLP-1 receptor agonists.)*

☐ The dose of the requested medication is currently being titrated

☐ The beneficiary is experiencing clinical benefit with the requested medication

☐ **Attestation from the prescriber:**

☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐ **The beneficiary is 18 years of age or older:**

Pre-treatment weight: _____ Current weight: _____

☐ **The beneficiary is less than 18 years of age:**

Pre-treatment BMI: _____ Current BMI: _____

Pre-treatment BMI z-score: _____ Current BMI z-score: _____

☐ **The beneficiary is being treated for a diagnosis OTHER THAN OBESITY.**

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	**Date**: