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

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 Hypoglycemics, Incretin Mimetic/Enhancer. See the Preferred Drug List (PDL) for the list of preferred Hypoglycemics, Incretin Mimetics/Enhancers at: https://papdl.com/preferred-drug-list.
2. A Hypoglycemics, Incretin Mimetic/Enhancer containing a glucagon-like peptide-1 (GLP-1) receptor agonist.
3. A drug containing a GLP-1 receptor agonist when there is a record of a recent paid claim for another drug containing a GLP-1 receptor agonist or a dipeptidyl peptidase 4 (DPP-4) inhibitor in the point-of-sale online claims adjudication system (therapeutic duplication).
4. A DPP-4 inhibitor when there is a record of a recent paid claim for another DPP-4 inhibitor or a drug containing 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 Hypoglycemics, Incretin Mimetic/Enhancer, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 receptor agonist, **both** of the following:
    a. **One** of the following:
        i. For the treatment of diabetes, has at least **one** of the following:
            a) A diagnosis of diabetes mellitus
            b) A history of an antidiabetic drug (excluding drugs containing a GLP-1 receptor agonist) within the last 120 days
        ii. For the treatment of overweight or obesity, **all** of the following:
            a) **One** 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, cardiovascular disease, 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,

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

c) Is age- and weight-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

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

e) Does not have a contraindication to the prescribed drug

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

i. For the treatment of overweight or obesity, has history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

a) The preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist on the PDL medically accepted for the beneficiary's diagnosis
b) The preferred Obesity Treatment Agents containing a GLP-1 receptor agonist on the PDL medically accepted for the beneficiary's diagnosis

See the PDL for the list of preferred Hypoglycemics, Incretin Mimetics/Enhancers and Obesity Treatment Agents containing a GLP-1 receptor agonist at: https://papdl.com/preferred-drug-list.

ii. For the treatment of all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist 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 drug containing a GLP-1 receptor agonist or a DPP-4 inhibitor, **one** of the following:

a. Is being transitioned to or from another drug containing a GLP-1 receptor agonist or DPP-4 inhibitor with the intent of discontinuing one of the drugs
b. Has a medical reason for concomitant use of the requested drugs 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 HYPOGLYCEMICS, INCRETIN MIMETIC/ENHANCER CONTAINING A GLP-1 RECEPTOR AGONIST FOR A DIAGNOSIS OF OVERWEIGHT OR OBESITY: The determination of medical necessity of a request for renewal of a prior authorization for a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 receptor agonist for a diagnosis of overweight or obesity that was previously approved will take into account whether the beneficiary:

1. **One** of the following:
    a. Is continuing with dose titration,
    b. **One** of the following:
        i. For beneficiaries 18 years of age and older, 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
        ii. For beneficiaries less than 18 years of age, 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. Experienced improvement in degree of adiposity or waist circumference from baseline,
    d. Experienced clinical benefit from the drug containing a GLP-1 receptor agonist in at least one weight-related comorbidity from baseline as determined by the prescriber, such as dyslipidemia, hypertension, type 2 diabetes, prediabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc;
    AND
2. Has been counseled about lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity); **AND**
3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
4. Does not have a contraindication to the prescribed drug; **AND**

5. For a non-preferred Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 receptor agonist, has history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

   a. The preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist on the PDL medically accepted for the beneficiary's diagnosis
   b. The preferred Obesity Treatment Agents containing a GLP-1 receptor agonist on the PDL medically accepted for the beneficiary's diagnosis

   See the PDL for the list of preferred Hypoglycemics, Incretin Mimetics/Enhancers and Obesity Treatment Agents containing a GLP-1 receptor agonist at: https://papdl.com/preferred-drug-list;

   AND

6. For therapeutic duplication of a drug containing a GLP-1 receptor agonist, **one** of the following:

   a. Is being transitioned to or from another drug containing a GLP-1 receptor agonist or DPP-4 inhibitor with the intent of discontinuing one of the drugs
   b. Has a medical reason for concomitant use of the requested drugs 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 Hypoglycemics, 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

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

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

PRIOR AUTHORIZATION FORM *(form effective 9/2/2024)*

☐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. *Check all that apply and submit documentation for each item.*

INITIAL requests

1. **For requests for SYMLIN (pramlintide),** submit chart documentation supporting the use of Symlin.

2. **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.)*

3. **For a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST:**
   ☐The beneficiary is being treated for or has a diagnosis of DIABETES

   ☐The beneficiary is being treated for OVERWEIGHT or OBESITY and:
   - ☐**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 and:**
     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:
       ☐cardiovascular disease ☐obstructive sleep apnea
       ☐dyslipidemia ☐prediabetes
       ☐hypertension ☐type 2 diabetes
       ☐metabolic syndrome ☐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:
       ☐cardiovascular disease ☐obstructive sleep apnea
       ☐dyslipidemia ☐prediabetes
       ☐hypertension ☐type 2 diabetes
       ☐metabolic syndrome ☐other (list): _____
   - ☐**The beneficiary is less than 18 years of age and:**
     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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☐ **For a NON-PREFERRED Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST** (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred products containing a GLP-1 receptor agonist.*)**:**

☐ **For the treatment of OVERWEIGHT OR OBESITY:**
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Ozempic
  - ☐ Trulicity
  - ☐ Victoza
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Saxenda
  - ☐ Wegovy
  - ☐ Zepbound

☐ **For the treatment of ALL OTHER diagnoses:**
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Ozempic
  - ☐ Trulicity
  - ☐ Victoza

RENEWAL requests

☐ **For a Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST for the treatment of OBESITY:**

☐ **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: _____

☐ At least **one** of the following:
- ☐ The dose of the requested medication is currently being titrated
- ☐ The beneficiary experienced a percent reduction in body weight (for beneficiaries 18 years of age or older) or BMI or BMI z-score (for beneficiaries less than 18 years of age) that is consistent with the recommended cutoff in the FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose
- ☐ The beneficiary experienced an improvement in degree of adiposity or waist circumference from baseline
- ☐ The beneficiary experienced clinical benefit with the requested medication in at least one weight-related comorbidity from baseline, such as dyslipidemia, hypertension, type 2 diabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.

☐ **Attestation from the prescriber:**
- ☐ The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

☐ **Request is for a NON-PREFERRED Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST** (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*)**:**
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Ozempic
  - ☐ Trulicity
  - ☐ Victoza
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Saxenda
  - ☐ Wegovy
  - ☐ Zepbound

☐ **The beneficiary is being treated for a diagnosis OTHER THAN OVERWEIGHT OR OBESITY or the request is for a DPP-4 INHIBITOR or SYMLIN (pramlintide).**

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: