

**Hypoglycemics, Incretin Mimetics/Enhancers  
 (GLP-1/GIP Agonists for Use in Diabetes)  
 Clinical Prior Authorization (PA) Request Form  
 CT Medical Assistance Program  
To Be Completed By Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient Date of Birth:
Phone (        )	Patient Current Weight:
Fax (        )	Patient Primary ICD Diagnosis Code:

<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

<u>Preferred Agents:</u>	<u>Non-Preferred Agents:</u>
BYETTA OZEMPIC DOSE PEN, SYRINGE TRULICITY PEN VICTOZA PEN	BYDUREON BCISE AUTOINJECT EXENATIDE PEN LIRAGLUTIDE PEN (generic VICTOZA) MOUNJARO PEN RYBELSUS TABLET SOLIQUA PEN XULTOPHY PEN

**Clinical Information**

(attach supporting documentation, **required**)

*Note: Using samples to initiate therapy does not meet authorization requirements*

1. Patient has a documented diagnosis of type 2 diabetes mellitus defined by one of more of the following (must be documented in attached chart note or attached laboratory results): <ul style="list-style-type: none"> <li>• A1c <math>\geq</math> 6.5% (<math>\geq</math> 48 mmol/mol)</li> <li>• Fasting Plasma Glucose <math>\geq</math> 126 mg/dL (<math>\geq</math> 7.0 mmol/L)</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<ul style="list-style-type: none"> <li>Two-hour plasma glucose <math>\geq 200</math> mg/dL (<math>\geq 11.1</math> mmol/L) during Oral Glucose Tolerance Test</li> <li>Classic symptoms of Hyperglycemia (e.g., polyuria, polydipsia, and unexplained weight loss) OR Hyperglycemic Crisis (diabetic ketoacidosis or hyperglycemic hyperosmolar state) AND a Random Plasma Glucose <math>\geq 200</math> mg/dL (<math>\geq 11.1</math> mmol/L)</li> </ul>	
<p>2. Will the requested agent be used in combination with another GLP agonist containing therapy?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Will the requested agent be used in combination with a DPP-4 inhibitor containing therapy?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Patient has trialed and failed ONE preferred agent for a minimum of 30 days as defined by failure to improve or maintain improvement in glycemic control OR patient has a documented adverse reaction/adverse event or contraindication to ALL preferred agents:</p> <ul style="list-style-type: none"> <li>Preferred agent trialed: _____</li> <li>Trial Dates: _____</li> <li>Reason for Failure</li> </ul> <p><b>If insufficient response, please specify</b> (<i>Note: Submission of laboratory values dated after the initiation of treatment with the preferred agent are required in order to demonstrate insufficient response</i>): _____</p> <p>Baseline laboratory value: _____ Date obtained: _____</p> <p>Follow-up laboratory value: _____ Date obtained: _____</p> <p><b>OR</b></p> <p><b>If adverse reaction, adverse event, or contraindication, please specify</b> (<i>Note: Gastrointestinal side effects are not considered an intolerance as they are expected class effects unless medical justification for discontinuation is provided by prescriber</i>): _____</p> <p>_____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**For Initial Approval:**

**Medication Requested and Documented diagnosis of ONE of the following:**

(attach supporting documentation, required)

<p><b><u>Exenatide (18+ years of age):</u></b></p> <ul style="list-style-type: none"> <li>Patient has a documented diagnosis of Type 2 Diabetes Mellitus AND</li> <li>Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined in Question 4 of the Clinical information section) AND</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<ul style="list-style-type: none"> <li>• Provider attests that Exenatide will be used <u>alongside diet and exercise</u></li> </ul>	
<p><b><u>Liraglutide (generic Victoza) (10+ years of age):</u></b></p> <ul style="list-style-type: none"> <li>• Patient has a documented diagnosis of Type 2 Diabetes Mellitus <b>AND</b></li> <li>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 4 of the Clinical information section) <b>AND</b></li> <li>• Provider attests to ALL the following (provide documentation): <ul style="list-style-type: none"> <li>○ Liraglutide will be used <u>alongside diet and exercise</u></li> <li>○ Patient does not have a personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2) <b>AND</b></li> </ul> </li> <li>• Documented medical reason the preferred BRAND Victoza cannot be utilized: _____ _____</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b><u>Mounjaro (tirzepatide) (10+ years of age):</u></b></p> <ul style="list-style-type: none"> <li>• Patient has a documented diagnosis of Type 2 Diabetes Mellitus <b>AND</b></li> <li>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 4 of the Clinical information section) <b>AND</b></li> <li>• Provider attests to ALL the following (provide documentation): <ul style="list-style-type: none"> <li>○ Mounjaro will be used <u>alongside diet and exercise</u></li> <li>○ Patient does not have a personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2)</li> </ul> </li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b><u>Rybelsus (semaglutide) (18+ years of age):</u></b></p> <ul style="list-style-type: none"> <li>• Patient has a documented diagnosis of Type 2 Diabetes Mellitus <b>AND</b></li> <li>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 4 of the Clinical information section) <b>AND</b></li> <li>• Provider attests to ALL the following (provide documentation): <ul style="list-style-type: none"> <li>○ Rybelsus will be used <u>alongside diet and exercise</u></li> <li>○ Patient does not have a personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2)</li> </ul> </li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b><u>Soliqua (insulin glargine/lixisenatide) (18+ years of age):</u></b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> <li>• Patient has a documented diagnosis of Type 2 Diabetes Mellitus <b>AND</b></li> <li>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 4 of the Clinical information section) <b>AND</b></li> <li>• Provider attests to ALL the following (provide documentation): <ul style="list-style-type: none"> <li>○ Soliqua will be used <u>alongside diet and exercise</u></li> <li>○ Patient does not have frequent episodes of hypoglycemia</li> </ul> </li> </ul>	
<p><b><u>Xultophy (insulin degludec/liraglutide) (18+ years of age):</u></b></p> <ul style="list-style-type: none"> <li>• Patient has a documented diagnosis of Type 2 Diabetes Mellitus <b>AND</b></li> <li>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 4 of the Clinical information section) <b>AND</b></li> <li>• Provider attests to ALL the following (provide documentation): <ul style="list-style-type: none"> <li>○ Xultophy will be used <u>alongside diet and exercise</u></li> <li>○ Patient does not have frequent episodes of hypoglycemia</li> <li>○ Patient does not have a personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2)</li> </ul> </li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No

### **Renewal Information**

(attach supporting documentation, **required**)

*Note: Using samples to initiate therapy does not meet renewal authorization requirements*

<ul style="list-style-type: none"> <li>• Has the patient previously met the required criteria set forth in Initial Approval Section above? <ul style="list-style-type: none"> <li>○ Previous Approved Prior Authorization Number: _____</li> <li>○ Approval Dates: _____</li> </ul> </li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>• Patients' clinical response to treatment and ongoing safety has been monitored and patient is compliant on current therapy regimen</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>• Prescriber attests to ONE of the following (documentation <b>MUST</b> be attached) <ul style="list-style-type: none"> <li>○ Attached laboratory values document improvement in glycemic control <ul style="list-style-type: none"> <li>▪ Baseline HgbA1c: _____ Date obtained: _____</li> <li>▪ Recent (within 180 days of submission) HgbA1c: _____ Date obtained: _____</li> </ul> </li> </ul> <p><b>OR</b></p> </li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> <li>○ Attached laboratory values document that patient is at glycemic control goal <ul style="list-style-type: none"> <li>▪ Recent (within 180 days of submission) HgbA1c: _____ Date obtained: _____</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>● <u>For Liraglutide (generic Victoza) Renewal:</u> Documented medical reason the preferred BRAND Victoza cannot be utilized: _____ _____</li> </ul>	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

**Prescriber Signature\*:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\* Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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