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Government of District of Columbia Department of Health Care Finance

GLP-1 receptor agonist FDA labeled Indication for Diabetes Mellitus Type II Prior Authorization Request

REQUEST DATE:

PATIENT INFORMATION

PATIENT MEDICAID ID: _____ **DATE OF BIRTH:** _____

PATIENT LAST NAME: _____

PATIENT FIRST NAME: _____ **MIDDLE INITIAL:** _____

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME: _____

PRESCRIBER FIRST NAME: _____

PRESCRIBER PHONE: _____ **PRESCRIBER FAX:** _____

PRESCRIBER DEA NUMBER: _____ **PRESCRIBER NPI NUMBER:** _____

PHYSICIAN SPECIALTY: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY PHONE: _____ **PHARMACY FAX:** _____

PHARMACY NPI NUMBER: _____

Refer to FDA www.fda.gov for prescribing details and approved indications.

***Please refer to the Preferred Drug List (PDL). Preferred are Tier 1 and non-preferred are Tier 2.**

PRIOR AUTHORIZATION CRITERIA

1. **Does the member have a diagnosis of Type 2 Diabetes (not pre-diabetes)?** ☐ Yes ☐ No
   *Please note GLP-1 drugs FDA labeled for weight loss are excluded from coverage for the District DHCF Pharmacy Program.
2. **Has the patient tried and had an inadequate response to an agent containing metformin or insulin?** ☐ Yes ☐ No
   - **If yes, please specify agent attempted:** _____
   - **If no, does the patient have an intolerance or hypersensitivity to metformin or insulin?** ☐ Yes ☐ No
     - **If yes, please explain intolerance or hypersensitivity:** _____
     - **If no, does the patient have an FDA labeled contraindication to BOTH metformin AND insulin?** ☐ Yes ☐ No
       - **If yes, please specify contraindication:** _____
3. **Please provide lab value for HgA1C (within the last 90 days):** _____
   - **Date for the above test:** _____
4. **Will the requested drug be used in combination with any other GLP-1 receptor agonist?** ☐ Yes ☐ No
5. **Does the patient have a history of pancreatitis?** ☐ Yes ☐ No
6. **Does the patient have a personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)?** ☐ Yes ☐ No
7. **Is dosing appropriate as per labeling or supported by peer-reviewed database? If not, provide clinical documentation that supports the safety and efficacy of the use of this drug for this treatment.** ☐ Yes ☐ No

PRIOR AUTHORIZATION CRITERIA

Length of authorization: **up to 6 months**

Fax to: District of Columbia Pharmacy Program
Phone: 800-273-4962
Fax: 866-535-7622

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PRIOR AUTHORIZATION RENEWAL

1. **Does the patient continue to meet the initial review criteria?** ☐ Yes ☐ No
2. **Please provide updated lab value post treatment for HgA1C:**_____

   Date for the above test: _____
3. **Has the patient experienced any treatment-restricting adverse effects (e.g., thyroid C-cell tumors, acute pancreatitis, acute gallbladder disease, acute kidney injury, hypoglycemia, hypersensitivity reactions, diabetic retinopathy, heart rate increase, suicidal behavior, and ideation)?** ☐ Yes ☐ No
4. **Is dosing appropriate as per labeling or supported by peer-reviewed database? If not, provide clinical documentation that supports the safety and efficacy of the use of this drug for this treatment.** ☐ Yes ☐ No

DOSAGE AND ADMINISTRATION

Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/.

I certify that, to the best of my knowledge, all the information I have provided on this request is complete and factual.

Prescriber's Signature: _____ **Date**: _____

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