Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
GLP-1 Receptor Agonists for Type 2 DM Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **GLP-1 Receptor Agonists for Type 2 DM.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Does patient have diagnosis of diabetes mellitus type 2?
   □ No □ Yes

2. Does patient meet the age cutoffs below?
   a. ≥10 years old for Bydureon, Victoza, and Trulicity
   b. ≥18 years old for Xultophy, Soliqua, Ozempic, and Rybelsus
   □ No □ Yes

3. Please indicate HbA1c goal: _____
   AND last HbA1c lab result (must be within 90 days): _____ Date: _____

4. **AND** does patient have any intolerance or contraindications or hypersensitivity reactions to GLP-1 receptor agonists including: risk of thyroid C-cell tumors (observed in rat studies), multiple endocrine neoplasia syndrome type 2 (MEN2), history or family history of medullary thyroid carcinoma (MTC), and pancreatitis?
   □ No □ Yes

5. **AND** does patient have severe renal function (CrCl < 30 mL/min)?
   □ No □ Yes

6. **AND** has patient had adequate trial (90 days) of KP-preferred oral medications: metformin, sulfonylurea, pioglitazone, AND Jardiance (empagliflozin) at maximum tolerated dose unless resulting in a therapeutic failure, contraindication, or intolerance (*Note: if patient has ASCVD or indicators of high ASCVD risk, only trials of metformin and Jardiance are required*)?
   □ No □ Yes

7. **AND** if patient is using a GLP-1 receptor agonist and prandial insulin concurrently, provider is aware that concurrent use has not been studied and should be used with caution?
   □ No □ Yes

8. **AND** if ordering a non-preferred GLP-1 receptor agonist, patient has had adequate trial of, intolerance, or contraindication to KP-preferred GLP-1 receptor agonist, Victoza (liraglutide)?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Is there documentation of continued medical necessity including HbA1c result within the last 90 days?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**