Prior Authorization Form
GLP-1 Agonists

INSTRUCTIONS FOR COMPLETING THIS FORM

Please fill out all sections on all pages completely and legibly. If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Use one form per member, per drug, please. This form, along with other PA forms can be found at: **https://welcome.optumrx.com/tenncare/landing.**

MEMBER INFORMATION

Member Last Name: _____
Member First Name: _____
Member ID: _____
Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female
Street Address: _____
City: _____ State: _____ ZIP: _____
Phone Number: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____
Prescriber First Name: _____
Prescriber NPI: _____ Prescriber DEA: _____
Specialty: _____ Office Phone: _____ Office Fax: _____
Supervising Physician and DEA (if applicable): _____
Office Street Address: _____
City: _____ State: _____ ZIP: _____
Is the prescriber a single patient contract holder for this patient? ☐ Yes ☐ No
Is the prescriber a TennCare provider with a TN Medicaid ID? ☐ Yes ☐ No

MEDICATION AND DISPENSING INFORMATION

Drug Name: _____ Drug strength: _____
Drug Formulation: _____ Dosing Frequency: _____
Quantity: _____ Day Supply: _____

With the exception of the "**Branded Drugs to be Classified as Generics List**," TennCare is a mandatory generic program in accordance with state law (TCA 53-10-205). Approval of Non-Preferred agents requires trial and failure, contraindication, or intolerance of two (2) preferred agents, unless otherwise indicated on the **PDL**.
Please refer to the **Preferred Drug List** or see below for Preferred and Non-Preferred Drugs in the GLP-1 Agonists class.

GLP-1 Agonists

Preferred Drugs	Non-Preferred Drugs
Ozempic® injection PA, QL	exenatide injection PA, QL
Victoza® injection PA, QL	liraglutide injection PA, QL (generic for Victoza®)
Wegovy® injection PA, QL	liraglutide injection PA, QL (generic for Saxenda®)
Zepbound® autoinjector PA, QL	Mounjaro® injection PA, QL
	Rybelsus® tablets PA, QL
	Saxenda® injection PA, QL
	Soliqua ® injection PA, QL
	Trulicity® injection PA, QL
	Xultophy® injection PA, QL

Member Last Name: _____ DOB: _____

CLINICAL CRITERIA

NOTE: Submission of medical records confirming diagnosis is required. Failure to provide the requested documentation will delay response.

Complete Questions 1-7 for ALL requests.

1. What is the diagnosis the requested agent is being used for?
   - ☐ Type 2 Diabetes
   - ☐ Obesity Management Therapy
   - ☐ CV Risk Reduction
   - ☐ Obstructive Sleep Apnea
   - ☐ NASH/MASH
   - ☐ Other: _____
2. Will the requested product be used concurrently with another GLP-1 receptor agonist? ☐ Yes ☐ No
3. Will the requested product be used concurrently with a DPP-4 Inhibitor (e.g., Janumet®, saxagliptin, Tradjenta®)? ☐ Yes ☐ No
4. Does the patient have a personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)? ☐ Yes ☐ No
5. Does the prescriber attest that the patient is participating in complementary nutritional and lifestyle changes (e.g., dietary modification, increased physical activity as medically able, structured behavioral intervention, comprehensive weight management program)? ☐ Yes ☐ No
6. Please note any other information pertinent to this PA request: _____
   _____
7. If the request is for a non-preferred drug (as listed above), has the patient failed, had an adverse event, or intolerance to a preferred drug? ☐ Yes ☐ No
   a. If yes, please list each drug tried and the result:
      Drug/Strength: _____ Length of trial: _____
      Reason for discontinuation: _____
      Drug/Strength: _____ Length of trial: _____
      Reason for discontinuation: _____

Please complete the question below applicable to the drug and indication being treated. For renewal requests, please complete Question 13 or 14.

8. Please complete this question for requests for **exenatide injection, liraglutide (generic for Victoza®) injection, Mounjaro® injection, Ozempic® injection, Rybelsus® tablets, Soliqua® injection, Trulicity® injection, Victoza® injection, or Xultophy® injection** AND the diagnosis is **Type 2 Diabetes.** *Prescriber must submit documentation to support responses to the following questions. *
   a. Please provide medical documentation (e.g., chart notes) of ONE of the following laboratory values:
      - ☐ HbA1c greater than or equal to 6.5%
        Note: HbA1c level can be from early stages in patient treatment. If original HbA1c is unknown, or current HbA1c is controlled due to another current diabetic regimen, please include current regiment and current HbA1c.
      - ☐ Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL
      - ☐ Two (2) hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test
      - ☐ Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis
   b. For requests for **Soliqua® or Xultophy® only**: is the patient currently taking, but inadequately controlled on, a long-acting insulin? ☐ Yes ☐ No

Continued on next page.

9. Please complete this question for requests for **Wegovy® injection** AND the diagnosis is **CV Risk Reduction.**
   Prescriber must submit documentation to support responses to the following questions.
   a. Please provide medical documentation (e.g., chart notes) for BOTH of the following:
      i. ☐ Initial body mass index (BMI) of ≥ 27 kg/m^2; **AND**
      ii. ONE of the following:
         ☐ Prior myocardial infarction
         ☐ Prior stroke (ischemic or hemorrhagic stroke)
         ☐ Symptomatic peripheral arterial disease as evidenced by intermittent claudication with ankle-brachial index < 0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease
   b. Patient is on optimized guideline-directed therapy including beta-blockers, RAS inhibitors, and lipid lowering agents to ensure reduced cardiovascular risk unless contraindicated (supported by medical documentation or claims history). ☐ Yes ☐ No
10. Please complete this question for requests for **liraglutide (generic for Victoza®) injection, Mounjaro® injection, Wegovy® injection, or Victoza® injection** AND the diagnosis is **NASH or MASH.**
    *Prescriber must submit documentation to support responses to the following questions. *
    a. Please provide medical documentation (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by ONE of the following:
       ☐ FibroScan
       ☐ Fibrosis-4 index (FIB-4)
       ☐ Magnetic Resonance Elastrography (MRE)
       ☐ Liver biopsy
    b. Is the medication prescribed by, or in consultation with, a gastroenterologist or hepatologist?
       ☐ Yes ☐ No
11. Please complete this question for requests for **liraglutide (generic for Saxenda®) injection, Saxenda® injection, Wegovy® injection, or Zepbound® autoinjector** AND the diagnosis is **Obesity Management Therapy**.
    *Prescriber must submit documentation to support responses to the following questions. *
    a. Please provide medical documentation (e.g., chart notes) of ONE of the following:
       i. ☐ For patients < 18 years of age, BMI is ≥ 95th percentile standardized for age and sex
       ii. For patients ≥ 18 years of age, one of the following:
          ☐ Initial body mass index (BMI) of ≥ 30 kg/m^2; **OR**
          ☐ BMI of > 27 kg/m^2 and a weight related comorbidity (e.g., hypertension, dyslipidemia, diabetes, coronary heart disease, MASH/NASH, obstructive sleep apnea)
    b. Does the prescriber attest that the patient is participating in complementary nutritional and lifestyle changes (e.g., dietary modification, increased physical activity as medically able, structured behavioral intervention, comprehensive weight management program)? ☐ Yes ☐ No
    c. Will the requested product be used concurrently with another FDA approved medication for obesity/weight loss? ☐ Yes ☐ No
12. Please complete this question for requests for **Zepbound® autoinjector** AND the diagnosis is **Obstructive Sleep Apnea (OSA)**. *Prescriber must submit documentation to support responses to the following questions.*
    a. Has hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medication/substance use been ruled out? ☐ Yes ☐ No
    b. Please provide documentation of BOTH of the following:
       ☐ Initial Body Mass Index (BMI) of ≥ 30 mg/k^2; **AND**
       ☐ 15 or more respiratory events per hour of sleep confirmed by sleep study
    c. Has the patient tried and failed (minimum duration of 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device, unless contraindicated? ☐ Yes ☐ No
       i. If yes, please list dates of CPAP or BiPAP trial and duration: _____

Continued on next page.

13. For Renewal Requests for ALL indications EXCEPT Obesity Management Therapy:
    a. Prescriber will submit medical records documenting a positive clinical response to therapy (e.g., reduction in HbA1c, achievement of HbA1c goal, improvement of fasting blood glucose levels, improvement in ASCVD, CKD, HF, NASH/MASH disease, symptoms, or risk factors, etc.). ☐ Yes ☐ No

    Note: submission of medical records documenting a positive clinical response to therapy is required for approval. Failure to provide the requested documentation will delay the response.
14. For Renewal Requests for Obesity Management Therapy:
    a. Has the patient continued participating in complementary nutritional and lifestyle changes (e.g., dietary medication, increased physical activity as medically able, structured behavioral intervention, comprehensive weight management program)? ☐ Yes ☐ No
    b. Will the medication be used in combination with other medications FDA approved for obesity/weight loss? ☐ Yes ☐ No
    c. The prescriber will submit medical records (e.g., chart notes) documenting a weight loss of ≥ 5% of baseline body weight. ☐ Yes ☐ No

    Note: submission of medical records documenting a positive clinical response to therapy is required for approval. Failure to provide the requested documentation will delay the response.

PRESCRIBER ATTESTATION

The prescriber attests that medical records containing relevant information related to the requested diagnosis will be submitted along with the Prior Authorization fax form. Submission of these records is required for approval. Failure to provide the necessary documentation may result in delays in processing the request.

☐ Yes ☐ No

PRESCRIBER SIGNATURE

By signature, the prescriber confirms the above information is accurate and verifiable by patient records.

Prescriber Signature: _____ Date: _____

INSTRUCTIONS FOR SUBMISSION

PA requests can be submitted to Optum Rx via fax (866-434-5523), by phone (866-434-5524), or by electronic PA request, such as CoverMyMeds. For questions, please call 1-866-434-5524. Optum Rx will provide a response within 24 hours upon receipt.