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.

For request for Obesity Management Therapy, please submit **Weight Management Agents PA Form**.

This document and others if attached contain information that is privileged, confidential, and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Optum Rx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing, or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Member Last Name: _____DOB: _____

GLP-1 Agonists

Preferred Drugs	Non-Preferred Drugs
Mounjaro® injection PA, QL	exenatide injection PA, QL
Ozempic® injection PA, QL	liraglutide injection PA, QL (generic for Victoza®)
Soliqua® injection PA, QL	Ozempic® tablets PA, QL
Wegovy® injection PA, QL	Rybelsus® tablets PA, QL
Zepbound® single dose prefilled pen PA, QL	Trulicity® injection PA, QL
	Victoza® injection PA, QL
	Wegovy® tablets PA, QL
	Xultophy® injection PA, QL
	Zepbound KwikPen® PA, QL

CLINICAL CRITERIA

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

Complete Questions 1-6 for ALL requests.

1. What is the diagnosis the requested agent is being used for?
   - ☐ Type 2 Diabetes
   - ☐ Obesity Management Therapy (Please submit **Weight Management Agents PA Form**.)
   - ☐ CV Risk Reduction
   - ☐ Obstructive Sleep Apnea
   - ☐ NASH/MASH
   - ☐ Other: _____
2. Will the requested product be used concurrently with another injectable or oral 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. Please note any other information pertinent to this PA request: _____
   _____
6. 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: _____

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Member Last Name: _____DOB: _____

Please complete the question below applicable to the drug and indication being treated. For renewal requests, please complete Question 11 or 12.

7. Please complete this question for requests for **exenatide injection, liraglutide (generic for Victoza®) injection, Mounjaro® injection, Ozempic® injection, Ozempic® tablets, 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® only**: is the patient currently taking a long-acting insulin verifiable by TennCare paid claims? ☐ Yes ☐ No
   c. For requests for **Xultophy® only**: is the patient currently taking, but inadequately controlled on, a long-acting insulin? ☐ Yes ☐ No

8. Please complete this question for requests for **Wegovy® injection or Wegovy® tablets** AND the diagnosis is **CV Risk Reduction.** For request for Obesity Management Therapy, please submit **Weight Management Agents PA Form**.
   *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. 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. 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
   d. If the request is for **Wegovy tablets**, what is the reason why the patient cannot use Wegovy injection? __
      _____
      _____

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9. 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.** For request for Obesity Management Therapy, please submit **Weight Management Agents PA Form**.
   *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) greater than 1.3
      ☐ ELF score
      ☐ Magnetic Resonance Elastography (MRE)
      ☐ Liver biopsy
   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. Is the medication prescribed by, or in consultation with, a gastroenterologist or hepatologist? ☐ Yes ☐ No

10. Please complete this question for requests for **Zepbound® single dose prefilled pen or Zepbound KwikPen®** AND the diagnosis is **Obstructive Sleep Apnea (OSA)**. For request for Obesity Management Therapy, please submit **Weight Management Agents PA Form**.
    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: _____
    d. If the request is for **Zepbound KwikPen®**, what is the reason why the patient cannot use the preferred Zepbound single dose prefilled pen?_____
       _____
       _____

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11. 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
    b. For renewal request for **Wegovy® injection or tablets for CV Risk Reduction**: Prescriber will submit medical records demonstrating patient is on optimized guideline directed therapy including beta blockers, RAS inhibitors, and lipid lowering agents to ensure reduced cardiovascular risk unless contraindicated.
    ☐ 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.)
    c. For renewal requests for **Wegovy® tablets:**
        a. ONE of the following:
            i. Claims data will support that patient is currently taking the 25 mg daily maintenance dose: ☐ Yes ☐ No
            ii. Medical records will be submitted to demonstrate a positive clinical response (e.g., decrease in body weight, blood pressure, heart rate, etc.) with no adverse effects (e.g., nausea, diarrhea, constipation, hypoglycemia, acute pancreatitis/gallbladder disease, etc.) on a lower maintenance dose. ☐ Yes ☐ No

12. For Renewal Requests for Obesity Management Therapy: please submit **Weight Management Agents PA Form**.

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.

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