



HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

PRIOR AUTHORIZATION FORM (form effective 9/2/2024)

Prior authorization guidelines for **Hypoglycemics, Incretin Mimetics/Enhancers** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. For requests for **SYMLIN (pramlintide)**, submit chart documentation supporting the use of Symlin.
2. For a **NON-PREFERRED DPP-4 INHIBITOR**:
 - Tried and failed or has a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 INHIBITORS that are approved or medically accepted for the beneficiary's diagnosis or indication (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers DPP-4 inhibitors.*)
3. For a **Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST**:
 - The beneficiary is being treated for or has a diagnosis of DIABETES
 - The beneficiary is being treated for OVERWEIGHT or OBESITY and:
 - Attestation from the prescriber:**
 - The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity
 - The beneficiary is 18 years of age or older and:**
 - Pre-treatment weight: _____ Pre-treatment BMI: _____
 - Has a BMI greater than or equal to 30 kg/m²



Has a BMI greater than or equal 27 kg/m² and less than 30 kg/m² AND at least one of the following weight-related comorbidities:

- | | |
|---|--|
| <input type="checkbox"/> cardiovascular disease | <input type="checkbox"/> obstructive sleep apnea |
| <input type="checkbox"/> dyslipidemia | <input type="checkbox"/> prediabetes |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> type 2 diabetes |
| <input type="checkbox"/> metabolic syndrome | <input type="checkbox"/> other (list): _____ |

Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for beneficiary's ethnicity, etc. AND has at least one of the following weight-related comorbidities:

- | | |
|---|--|
| <input type="checkbox"/> cardiovascular disease | <input type="checkbox"/> obstructive sleep apnea |
| <input type="checkbox"/> dyslipidemia | <input type="checkbox"/> prediabetes |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> type 2 diabetes |
| <input type="checkbox"/> metabolic syndrome | <input type="checkbox"/> other (list): _____ |

The beneficiary is **less than 18 years of age** and:

Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

For a **NON-PREFERRED Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST** (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist.):

For the treatment of **OVERWEIGHT OR OBESITY**:

Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:

- Ozempic
- Trulicity
- Victoza

Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:

- Saxenda
- Wegovy
- Zepbound

For the treatment of **ALL OTHER** diagnoses:

Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:

- Ozempic
- Trulicity
- Victoza

RENEWAL requests

For a **Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST** for the treatment of **OBESITY**:

The beneficiary is **18 years of age or older**:

Pre-treatment weight: _____ Current weight: _____

The beneficiary is **less than 18 years of age**:

Pre-treatment BMI: _____ Current BMI: _____



Pre-treatment BMI z-score: _____ Current BMI z-score: _____

At least **one** of the following:

- The dose of the requested medication is currently being titrated
- The beneficiary experienced a percent reduction in body weight (for beneficiaries 18 years of age or older) or BMI or BMI z-score (for beneficiaries less than 18 years of age) that is consistent with the recommended cutoff in the FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose
- The beneficiary experienced an improvement in degree of adiposity or waist circumference from baseline
- The beneficiary experienced clinical benefit with the requested medication in at least one weight-related comorbidity from baseline, such as dyslipidemia, hypertension, type 2 diabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.

Attestation from the prescriber:

- The beneficiary was counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity

Request is for a **NON-PREFERRED Hypoglycemics, Incretin Mimetic/Enhancer containing a GLP-1 RECEPTOR AGONIST** (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.):

- Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
 - Ozempic
 - Trulicity
 - Victoza
- Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
 - Saxenda
 - Wegovy
 - Zepbound

The beneficiary is being treated for a diagnosis **OTHER THAN OVERWEIGHT OR OBESITY** or the request is for a **DPP-4 INHIBITOR** or **SYMLIN** (pramlintide).

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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