Print Reset

Prior Authorization Request Prescriber Fax

Glucagon-Like Peptide 1 (GLP-1) Receptor Agonists

Fax this form to 800-424-3260

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit primetherapeutics.com.

What is the priority level of this request?

- ☐ Standard
- ☐ Date of service (if applicable): _____
- ☐ Urgent (**Note**: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA

Note: Please attach any additional information that should be considered with this request.

Patient Diagnosis:

☐ Diabetes mellitus type 2

☐ Other (ICD Code): _____

ICD Description: _____

For all requests:

1. Is the patient currently being treated with the requested agent?
   ☐ Yes ☐ No
2. Has the patient been treated with a preferred agent within the past 90 days? The preferred agents are Bydureon, Mounjaro, Ozempic, Rybelsus, and Trulicity.
   ☐ Yes ☐ No

   If **Yes**, was the patient started on samples?
   ☐ Yes ☐ No

   If Yes, is the patient at risk if therapy with a preferred agent is discontinued?
   ☐ Yes ☐ No

   If Yes, please explain risk:

   _____
3. Does the requested quantity (dose) exceed the maximum FDA-labeled dose for the requested diagnosis, or does the requested agent not have a maximum FDA-labeled dose for the requested diagnosis?
   ☐ Yes ☐ No

   If Yes, please provide information to support therapy with a higher quantity (dose) for the requested diagnosis:

   _____

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

If No, can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit?

☐ Yes ☐ No

If No, please explain why the requested dose cannot be optimized:

_____

4. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives:

_____

5. Please list all medications that the patient has previously tried and failed for treatment of this diagnosis. (Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.)

Medication: _____ Type: _____

Date (from): _____ Date (to): _____

Medication: _____ Type: _____

Date (from): _____ Date (to): _____

Medication: _____ Type: _____

Date (from): _____ Date (to): _____

Diabetes mellitus type 2 requests:

6. Does the patient have a diagnosis of type 2 diabetes mellitus?

☐ Yes ☐ No

If Yes, what lab tests were used to confirm the patient's diagnosis? **Please provide the result of the lab tests and attach any documentation of the tests**

☐ A1C: _____

☐ Glucose Tolerance Test (OGTT): _____

☐ Fasting Plasma Glucose Test (FPG): _____

☐ Random Plasma Glucose Test: _____

☐ Other (please specify and provide result):

_____

7. Does the patient have or is at high risk for atherosclerotic cardiovascular disease, heart failure, or chronic kidney disease?

☐ Yes ☐ No

8. Has the patient tried and had an inadequate response to an agent containing metformin or insulin?

☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

If Yes, please specify agent(s) tried:

_____

If No, does the patient have an intolerance or hypersensitivity to metformin or insulin?

☐ Yes ☐ No

If Yes, please explain intolerance/hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to **both** metformin **and** insulin?

☐ Yes ☐ No

If Yes, please specify contraindication(s):

_____

For Adlyxin and Byetta and Victoza requests:

9. Has the patient tried and had an inadequate response to semaglutide (Ozempic **or** Rybelsus) after at least a 90-day duration of therapy?

   ☐ Yes ☐ No

   If No, does the patient have an intolerance, hypersensitivity, or an FDA-labeled contraindication to semaglutide (Ozempic **or** Rybelsus)?

   ☐ Yes ☐ No

   If Yes, please explain intolerance/hypersensitivity or specify contraindication:

   _____

10. Has the patient tried and had an inadequate response to dulaglutide (Trulicity) after at least a 90-day duration of therapy?

    ☐ Yes ☐ No

    If No, does the patient have an intolerance, hypersensitivity, or an FDA-labeled contraindication to dulaglutide (Trulicity)?

    ☐ Yes ☐ No

    If Yes, please explain intolerance/hypersensitivity or specify contraindication:

    _____

11. Has the patient tried and had an inadequate response to tirzepatide (Mounjaro) after at least a 90-day duration of therapy?

    ☐ Yes ☐ No

    If No, does the patient have an intolerance, hypersensitivity, or an FDA-labeled contraindication to tirzepatide (Mounjaro)?

    ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

If Yes, please explain intolerance/hypersensitivity or specify contraindication:

_____

☐ Attachments

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

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

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-3312

Fax this form to 800-424-3260