

**HYPOGLYCEMICS, INCRETIN
MIMETICS/ENHANCERS
PRIOR AUTHORIZATION FORM**
(form effective 9/2/2024)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

<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

- For requests for SYMLIN (pramlintide)**, submit chart documentation supporting the use of Symlin.
- 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.*)
 - List preferred medications tried: _____
- 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 to 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

**INITIAL REQUESTS (continued)**

- ☐ 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

Prescriber signature:

Date:

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