Clinical Policy Title:	Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists
Policy Number:	RxA.799
Drug(s) Applied:	Bydureon BCise®, Trulicity®, Byetta®, Ozempic®, Rybelsus®, Mounjaro®, Victoza ®, liraglutide
Original Policy Date:	07/13/2023
Last Review Date:	11/14/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial and Continued Approval Criteria:

A. Advanced Prior Authorization: Type 2 Diabetes Mellitus

1. Diagnosis of Type 2 Diabetes Mellitus confirmed by historical ICD-10 code: E11

B. Type 2 Diabetes Mellitus (must meet all):

1. Member meets one of the following (a or b):
   a. Member requires ongoing treatment for type 2 diabetes mellitus and has submitted medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus;
   b. Submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by one of the following laboratory values (i, ii, iii, or iv):
      i. A1C ≥ 6.5%;
      ii. Fasting plasma glucose (FPG) ≥ 126 mg/dL;
      iii. 2-hour plasma glucose (PG) ≥ 200 mg/dL during OGTT (oral glucose tolerance test);
      iv. Random plasma glucose ≥ 200 mg/dL;
2. Medication is not prescribed concurrently with the following (a and b):
   a. Another glucagon-like peptide (GLP-1) receptor agonist;
   b. Additional strengths of the same GLP-1 receptor agonist.

Approval Duration:
All Lines of Business (except Medicare): 12 months

C. Duplicate therapy override (must meet all)**:**

1. Member must have been on the maintenance dose for at least 4 weeks;
2. Medication is not prescribed concurrently with the following (a and b):
   a. Another glucagon-like peptide (GLP-1) receptor agonist;
   b. Additional strengths of the same GLP-1 receptor agonist.

Approval Duration:
All Lines of Business (except Medicare): 7 days

References:

1. American Diabetes Association. Introduction: standards of medical care in diabetes—2022. Diabetes Care. 2022;45(Supplement_1): S1-S2. Available at: https://doi.org/10.2337/dc22-Sint. Accessed June 16, 2023.

Review/Revision History	Review/Revision Date	P&T Approval Date

Policy established.	06/16/2023	07/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy reviewed. 1. Removed requirement for t/f Metformin 2. Removed age and dosing criteria 3. Removed ASCV, CKD criteria	3/1/2024	2/28/2024
Policy Reviewed: 1. Added diagnostic criteria: Random blood glucose 2. Added APA criteria	4/15/2024	4/15/2024
Policy Review: 1. Added duplicate therapy criteria 2. Removed Victoza	11/14/2024	12/05/2024