





Fax Completed Form To 1.833.404.2392

Prescriber Help Desk

1.833.587.2012

Online

covermymeds.com/main/

prior-authorization-forms/

Request for Prior Authorization Incretin Mimetics for Non-Diabetes Indications

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB				
Patient address						
Provider NPI	Prescriber name	Phone				
Prescriber address Fax						
Pharmacy name	Address	Phone				
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.						
Pharmacy NPI	Pharmacy fax NDC					

Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved for compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:

- 1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warning and precautions, drug interactions, and use in specific populations; and
- 2. Patient is ≥ 45 years of age; and
- 3. Patient has been screened for and does not have type 1 or type 2 diabetes mellitus (attach current lab results, obtained within 6 months of request, documenting an A1C < 6.5% or a fasting plasma glucose < 126 mg/dL); and
- 4. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
 - a. Patient has established CVD with history of one of the following (attach chart notes documenting diagnosis):
 - i. Prior myocardial infarction (MI);
 - ii. Prior stroke (ischemic or hemorrhagic);
 - iii. Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; and
 - b. Patient has a baseline body mass index (BMI) ≥ 27kg/m², obtained within 6 months of request; and
 - c. Patient has been evaluated for cardiovascular standard of care treatment; and
 - d. For Wegovy dosing:
 - i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
 - ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; and
- 5. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
- The requested agent will not be used in combination with other incretin mimetics.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose, will be considered when:

- 1. The requested drug will be used to reduce the risk of MACE; and
 - a. Patient does not have type 1 or type 2 diabetes; and

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- b. Patient has been evaluated for cardiovascular standard of care treatment; and
- For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg weekly is requested; and
- Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
- The requested agent will not be used in combination with other incretin mimetics.

Non-Pref	<u>erred</u>			
☐ Wego	vy			
	Strength	Usage Instructions	Quantity	Day's Supply
_				
Diagnosis	s:			
Initial Re	quests:			
-	ient have Type 1 lucose)?	or Type 2 Diabetes (attach lab reses No	sults documenting	current A1C or fasting
Patient h		VD documented by one of the fol	lowing (attach char	t notes documenting
	Prior myocardia			
	`	nemic or hemorrhagic)		
	• •	AD, as evidenced by:		
		audication with ABI less than 0.85 (, , , , , , , , , , , , , , , , , , ,	
	-	erial revascularization procedure, or	•	
	Amputation d	ue to atherosclerotic disease		
Provide	oatient's baseline	BMI:	Date Obtain	ed:
Has patie	ent been evaluate	d for cardiovascular standard of	care treatment? [Yes No
Will pation activity?		i <mark>cation in combination with a red</mark> No	uced calorie diet an	nd increased physical
Will the r	equested agent I	oe used in combination with othe	r incretin mimetics	? 🗌 Yes 🔲 No
<u>Renewal</u>	Requests:			
	ient have Type 1 llucose)?	or Type 2 Diabetes (attach lab res	sults documenting	current A1C or fasting
Has patie	ent been evaluate	d for cardiovascular standard of	care treatment? [Yes No

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Patient continues to use medication in combination with a reducactivity? Yes No	ed calorie diet and incr	eased physical				
Will the requested agent be used in combination with other incretin mimetics? Yes No						
Attach lab results and other documentation as necessary.						
Prescriber signature (Must match prescriber listed above.)	Date of submission					

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.

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