maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

GLP-1 Products

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient currently receiving the requested glucagon-like peptide-1 (GLP-1) product? [If no, skip to question 5.]	Yes	No
2	Has the patient been receiving medication samples for the requested GLP-1 product? [If yes, skip to question 5.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan for the requested GLP-1 product? [Note: If the patient does NOT have a previously approved PA on file for the	Yes	No

PRIOR AUTHORIZATION REQUEST

	requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 5.]		
4	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
5	What is the patient's diagnosis? [] Type 2 Diabetes Mellitus (If checked, go to 6) [] Other (If checked, no further questions)		
6	Is the patient CURRENTLY taking metformin? [If yes, skip to question 9.]	Yes	No
7	Did the patient have a previous inadequate response or adverse effect from metformin? [If yes, skip to question 9.]	Yes	No
8	Does the patient have any of the following contraindications to metformin: A) Renal dysfunction (serum creatinine greater than 1.4 mg per dL for females or greater than 1.5 mg per dL for males), B) Metabolic acidosis, C) Diabetic ketoacidosis? [If no, no further questions.]	Yes	No
9	What drug is being requested? [] Trulicity (If checked, go to 10) [] Rybelsus (If checked, go to 14) [] Bydureon pen (If checked, go to 10) [] Victoza 2-pak (If checked, go to 10) [] Byetta (If checked, go to 12) [] Mounjaro (If checked, go to 12) [] Ozempic SUBCUTANEOUS (If checked, go to 14) [] Liraglutide 2-pak (If checked, go to 15)		
10	How old is the patient? [] Greater than or equal to 10 years of age and less than or equal to 17 years of age (If checked, go to 11)		

PRIOR AUTHORIZATION REQUEST

[] Greater than or equal to 18 years of age (If checked, go to 13)

[] Other (If checked, no further questions)

11	Has the patient tried and failed liraglutide? [If yes, skip to question 16.] [If no, no further questions.]	Yes	No
12	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
13	Has the patient tried and failed ALL of the following formulary GLP-1 agonists for at least 3 months: A) Ozempic, B) Rybelsus, C) liraglutide? [If yes, skip to question 16.] [If no, no further questions.]	Yes	No
14	Is the patient greater than or equal to 18 years of age? [If yes, skip to question 16.] [If no, no further questions.]	Yes	No
15	Is the patient greater than or equal to 10 years of age? [If no, no further questions.]	Yes	No
16	Will the medication be used for the sole purpose of weight loss?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

If you have any questions, call:
1-888-258-8250