MedStar Family Choice
DISTRICT OF COLUMBIA

**All requests must be accompanied by MEDICAL RECORDS to support the request. MFC-DC MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL. Phone Inquiries: 855-798-4244**

# GLP-1 PRIOR AUTHORIZATION FORM

## Please fax 202-243-6258

Medication: GLP-1 Receptor Agonists (Mounjaro®, Ozempic®, Trulicity®)

| | |
|---|---|
| Patient's name: | DOB: |
| Patient's Phone #: | Medicaid ID: |

Medication Requested: ☐ Initial ☐ Renewal

| | | |
|---|---|---|
| Medication: | Strength/ Dose: | Quantity/ Days of Supply: |
| Prescriber: | NPI: | Date of Request: |

**Diagnosis/ICD-10**: _____

1. Is the patient ≥18 years of age with a confirmed diagnosis of Type 2 Diabetes Mellitus?
☐ Yes ☐No (Stop enrollee is not eligible)

2. For initial request: Is documentation of Hemoglobin A1c or Continuous Glucose Monitor (CGM) Time in Range (TIR) from the last 90 days attached? ☐ Yes ☐No (Stop enrollee is not eligible)

3. Does the patient meet Pathway 1 (A1c ≥7.5% OR TIR ≤60%)? ☐ Yes → Proceed to Question 5

4. If No, does the patient meet Pathway 2 (Established cardiovascular disease, BMI ≥27 kg/$m^2$, and A1c ≥6.5% OR TIR ≤70%)? ☐Yes ☐ No (Stop enrollee is not eligible)

5. Has the patient completed required step therapy? (Metformin ≥3 months or documented contraindication/intolerance; for Pathway 1, ≥3 months of TWO additional agents [insulin, sulfonylurea, pioglitazone, DPP-4 inhibitor, or SGLT2 inhibitor]; and ≥3 months of liraglutide [Victoza®] or documented contraindication/intolerance.) ☐Yes ☐ No (Stop enrollee is not eligible)

6. Is the patient free of concurrent GLP-1, GLP-1/GIP agonist, and DPP-4 inhibitor therapy?
☐Yes ☐ No (Stop enrollee is not eligible)

7. Does the patient have contraindications (medullary thyroid carcinoma, MEN2, pregnancy, or history of pancreatitis)? ☐ Yes ☐ No (Stop enrollee is not eligible)

8. For renewal requests only: Is documentation of Hemoglobin A1c or CGM Time in Range (TIR) from the last 6 months attached AND does it demonstrate clinical response or maintenance without serious adverse events? ☐Yes ☐ No (Stop enrollee is not eligible)

9. Required Documentation: ☐ Office Note ☐ A1c/CGM Report ☐ Medication History
☐ Cardiovascular Documentation (if applicable)

**By signing below, I certify that the information provided is accurate.**

Prescriber's Name: _____

Contact Person for Request: _____

Telephone #: (_____) - _____ Fax #: (_____) - _____

Prescriber Address: _____ _____

Prescriber Signature: _____ Date: _____