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. Does the patient have 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/m², and A1c ≥6.5% OR TIR ≤70%)? ☐Yes ☐ No (Stop enrollee is not eligible)

5. Has the patient completed required step therapy? Trial ≥3 months or documented contraindication/intolerance to TWO of the following agents [Metformin, 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. Ozempic injection only: CKD pathway

☐ eGFR 25 to <50 mL/min/1.73 m² AND uACR >100 mg/g

☐ **OR** eGFR 50 to 75 mL/min/1.73 m² AND uACR >300 mg/g

AND ☐ Yes ☐ No Trial of preferred SGLT2 inhibitor OR contraindication/intolerance (Stop enrollee is not eligible)

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

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

9. 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)

10. 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: _____