

# Antidiabetics – GLP-1 Agonists

Medical policy no. 27.17.00-1

Effective Date: TBD

*Note: New-to-market drugs included in this class based on the Apple Health Preferred Drug List are non-preferred and subject to this prior authorization (PA) criteria. Non-preferred agents in this class require an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least TWO preferred agents. If there is only one preferred agent in the class documentation of inadequate response to ONE preferred agent is needed. If a drug within this policy receives a new indication approved by the Food and Drug Administration (FDA), medical necessity for the new indication will be determined on a case-by-case basis following FDA labeling.*

## Background:

Glucagon-like peptide 1 (GLP-1) agonists, also called incretin mimetics, are used for the treatment of type 2 diabetes. GLP-1 causes the pancreas to produce more insulin after eating and helps keep blood glucose levels within the normal range. GLP-1 agonists mimic the action of GLP-1 made by the body and can affect glucose control through several mechanisms including enhancement of glucose-dependent insulin secretin, slowed gastric emptying, and reduction of postprandial glucagon and food intake.

## Medical necessity

Drug	Medical Necessity
Dulaglutide ( <b>Trulicity</b> ) Exenatide ( <b>Byetta</b> ) Exenatide Extended Release ( <b>Bydureon BCise</b> ) Liraglutide ( <b>Victoza</b> ) Lixisenatide ( <b>Adlyxin</b> ) Semaglutide subcutaneous, tablet ( <b>Ozempic, Rybelsus</b> )	GLP-1 agonists may be considered medically necessary in patients who meet the criteria described in the clinical policy below.  Preferred GLP-1 agonists do not require prior authorization. To see the list of the current Preferred and Non-Preferred products on the Apple Health Preferred Drug List (AHPDL), please visit: <a href="https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx">https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx</a>

## Clinical policy:

Clinical Criteria	
<b>Type 2 Diabetes Mellitus</b>	Non-Preferred GLP-1 Agonists may be approved when all of the following criteria are met: <ol style="list-style-type: none"> <li>1. Diagnosis of Type 2 diabetes; <b>AND</b></li> <li>2. Patient is 18 years of age or older; <b>AND</b></li> <li>3. Documentation of HbA1c <math>\geq</math> 6.5 measured within the past 12 months; <b>AND</b></li> <li>4. History of failure, defined as inability to achieve glycemic control; intolerance; contraindication or clinically inappropriate to <b>ALL (a-d)</b> of the following used separately or simultaneously for a minimum of 90 days:</li> </ol>

	<ol style="list-style-type: none"> <li>a. Metformin at maximum or highest tolerated dose</li> <li>b. One preferred SGLT2 inhibitor</li> <li>c. One preferred DPP4 inhibitor</li> <li>d. One preferred GLP-1; <b>AND</b></li> </ol> <p>If all the above criteria are met, the request will be approved for <b>12 months</b>.</p> <p>If all criteria are not met, but there are documented medically necessary or situational circumstances, based on the professional judgement of the clinical reviewer, requests may be approved on a case-by-case basis up to the initial authorization duration.</p>
	<b>Criteria (Reauthorization)</b>
	<ol style="list-style-type: none"> <li>1. Documentation showing HbA1c has improved from baseline</li> </ol> <p>If all the above criteria are met, the request will be approved for <b>12 months</b>.</p> <p>If all criteria are not met, but there are documented medically necessary or situational circumstances, based on the professional judgement of the clinical reviewer, requests may be approved on a case-by-case basis up to the reauthorization duration.</p>

## Dosage and quantity limits

Drug Name	Dose and Quantity Limits
Dulaglutide (TRULICITY)	<ul style="list-style-type: none"> <li>• 18 mg per 30 days</li> </ul>
Exenatide Extended Release (BYDUREON BCISE)	<ul style="list-style-type: none"> <li>• 8 mg per 30 days</li> </ul>
Lixisenatide (ADLYXIN)	<ul style="list-style-type: none"> <li>• 600 mcg per 30 days</li> </ul>
Semaglutide subcutaneous (OZEMPIC)	<ul style="list-style-type: none"> <li>• 4 mg per 30 days</li> </ul>
Semaglutide tablet (RYBELSUS)	<ul style="list-style-type: none"> <li>• 420 mg per 30 days</li> </ul>

## References

1. Adlyxin (lixisenatide) [prescribing information]. Bridgewater, NJ: Sanofi-Aventis US LLC; January 2019.
2. Bydureon (exenatide) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2020.
3. Glucagon-like peptide 1 receptor agonists for the treatment of type 2 diabetes mellitus. UpToDate. Wolters Kluwer Health, Inc. Riverwoods, IL. Accessed July 19, 2021. [https://www.uptodate.com/contents/glucagon-like-peptide-1-receptor-agonists-for-the-treatment-of-type-2-diabetes-mellitus?source=history\\_widget](https://www.uptodate.com/contents/glucagon-like-peptide-1-receptor-agonists-for-the-treatment-of-type-2-diabetes-mellitus?source=history_widget)
4. Ozempic (semaglutide) [prescribing information]. Plainsboro, NJ: Novo Nordisk Inc; April 2021.
5. Rybelsus (semaglutide) [prescribing information]. Plainsboro, NJ: Novo Nordisk Inc; January 2020.
6. Trulicity (dulaglutide) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; April 2021.

## History

Date	Action and Summary of Changes
06/14/2021	New policy created

DRAFT

## Antidiabetics – GLP-1 Agonists

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Without this information, we may deny the request in seven (7) working days.**

Apple Health Preferred Drug list: <https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx>

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	Qty/Days supply
<p>1. Is this request for a continuation of existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, is there documentation showing HbA1c has improved from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Indicate patient's diagnosis:  <input type="checkbox"/> Type 2 diabetes  <input type="checkbox"/> Other. Specify: _____</p> <p>3. Provide patient's HbA1c for the following:          Baseline: _____ Date taken: _____          Current (within last 12 mos.): _____ Date taken: _____</p> <p>4. List all medications patient has previously tried or has a history of failure, defined as inability to achieve glycemic control or, intolerance, and include any medications with contraindications or which are clinically inappropriate:</p> <p>How long were they on each medication?</p> <p>Why was each stopped or discontinued?</p>			
<b>Chart notes and documentation of HbA1c measurements are required with this request</b>			
Prescriber signature	Prescriber specialty	Date	