Glucagon Like Peptide-1 (GLP-1) Policy

Effective Date: 04/01/2026
Medical Care Management Committee Approval: 01/15/2026

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Coverage Policy

This Medical Review Guideline (Guideline) is provided for informational purposes only and does not constitute medical advice. It is intended solely for the use of Community Health Choice, Inc. (Community) clinical staff as a guideline for use in determining medical necessity of requested procedures, medications and therapy. This Guideline does not address eligibility or benefit coverage. Other Policies and Coverage Determination Guidelines may apply. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Review Guideline. If there is a discrepancy between this Guideline and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern. Community reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This policy applies to Community's Marketplace line of business.

This policy applies to the following GLP-1 products which are covered on Community's Marketplace formularies:

Glucagon Like Peptide-1 (GLP-1) Formulary Products
Bydureon (exenatide)
Byetta (exenatide)
Exenatide
Liraglutide
Mounjaro (tirzepatide)
Ozempic (semaglutide)
Rybelsus (semaglutide)
Trulicity (dulaglutide)
Victoza (liraglutide)

GLP-1 Coverage Criteria

Community will provide coverage for the formulary GLP-1 products based on the following criteria:

Initiation of therapy:

1. Member has evidence of diabetes, documentation required; AND
2. Member has tried an oral antidiabetic medication which was ineffective, contraindicated, or not tolerated; AND

Continuation of therapy:

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1. Member has a diagnosis of Type 2 diabetes mellitus; AND
2. Member has been previously approved for GLP-1 product through Community's prior authorization process; AND
3. Member has had a positive clinical response and is appropriate to continue treatment.

Prior Authorization Questions

Initiation of therapy:

1. Does the member have a diagnosis of Type 2 diabetes mellitus? **Documentation required.***
   - ☐ Yes (move to 2.)
   - ☐ No (deny)
2. Has the member had a trial of an ORAL antidiabetic medication which was ineffective, contraindicated, or not tolerated?
   - ☐ Yes (approve for 12 months)
   - ☐ No (deny)

   *Documentation may include, but is not limited to, chart notes or laboratory results.

Continuation of therapy:

1. Does the member have a diagnosis of Type 2 diabetes mellitus?
   - ☐ Yes (move to 2.)
   - ☐ No (deny)
2. Was GLP-1 previously approved through the member's current plan's Prior Authorization process [Note: patients not previously approved for the requested agent will require initial evaluation review]?
   - ☐ Yes (move to 3.)
   - ☐ No (review as initial therapy)
3. Has the member had a positive clinical response and it is appropriate for them to continue therapy?
   - ☐ Yes (approve)
   - ☐ No (deny)

Policy Revision History

Status	Effective Date	Description
Baseline	04/01/2026	Initial version of GLP-1 policy