Drug Prior Authorization
Glucagon Like Peptide-1 (GLP-1) Agonist

Fax completed form to CHC at: (713)848-6949
For questions, please call: (713)295-6704

COMMUNITY HEALTH CHOICE

| Request Information (required) | | | | | |
|---|---|---|---|---|---|
| This request is:<br>☐ Expedited* (Urgent)<br>☐ Standard (Non-Urgent)<br>*Expedited means the standard review time may seriously harm the member's life, health or ability to regain maximum function. | | | | | |
| **Member Information (required)** | | | **Prescriber Information (required)** | | |
| Member Name: | | | Prescriber Name: | | |
| Member Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Member Phone: | | | Office Fax: | | |
| Member Street Address: | | | Office Street Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |

| Please fill out the following information: |
|---|
| 1. Indicate Medication being Requested: (Please note, drugs below are a representative list, only. See plan formulary to verify coverage status.<br>☐ Dulaglutide (TRULICITY)<br>☐ Exenatide extended release (BYDUREON BCISE)<br>☐ EXENATIDE<br>☐ Liraglutide (VICTOZA)<br>☐ Semaglutide (OZEMPIC)<br>☐ Semaglutide (RYBELSUS)<br>☐ Tirzepatide (MOUNJARO)<br>☐ Other: |
| 2. Quantity Prescribed: |
| 3. Dosage Form: |
| 4. Strength & Route of Administration: |
| 5. Directions for use (include frequency and expected length of therapy): |

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| Coverage Determination Criteria (required) (approved for 1 year) |
|---|
| 6. Please select one:<br>☐ Initiation of therapy (go to #7)<br>☐ Continuation of therapy (go to #9) |
| 7. Does the member have a diagnosis of Type 2 diabetes mellitus? **Documentation required. ***<br>☐ Yes<br>☐ No<br>*Documentation may include, but is not limited to, chart notes or laboratory results. |
| 8. Has the member had a trial of an ORAL antidiabetic medication which was ineffective, contraindicated, or not tolerated?<br>☐ Yes<br>☐ No |
| 9. Does the member have a diagnosis of Type 2 diabetes mellitus?<br>☐ Yes<br>☐ No |
| 10. 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]?<br>☐ Yes (move to #11)<br>☐ No (move to #7, will review as initial therapy) |
| 11. Has the member had a positive clinical response and is it appropriate for them to continue therapy?<br>☐ Yes<br>☐ No |
| 12. Please provide any additional information we should consider, or attach any supporting documents: |

| Submission Information (required) | |
|---|---|
| Prescriber Signature: | Date: |

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If approved, coverage allowed for 1 year (subject to formulary changes).
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