BlueCross BlueShield Federal Employee Program

ANTIDIABETIC GLP-1, GIP-GLP-1 AGONISTS PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Antidiabetic GLP-1, GIP-GLP-1 Agonists

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Adlyxin injection (lixisenatide)** *Once-a-day dosing is equivalent to 6 pens per 84 days or 2 pens per 28 days. Each pen provides dosing for 2 weeks.*	**Will the patient need more than once-a-day FDA labeled dosing? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ units every 84 days**
❑**Bydureon/Bydureon BCise injection (exenatide)** *Once-a-week dosing is equivalent to 12 pens per 84 days or 4 pens per 28 days. Each pen provides dosing for 1 week.*	**Will the patient need more than once-a-week FDA labeled dosing? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ units every 84 days**
❑**Byetta injection (exenatide)** *Twice-a-day dosing is equivalent to 3 pens per 90 days or 1 pen per 30 days.*	**Will the patient need more than twice-a-day FDA labeled dosing? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ units every 90 days**
❑**Mounjaro (tirzepatide)** *Once-a-week dosing is equivalent to 12 pens per 84 days or 4 pens per 28 days. Each pen provides dosing for 1 week.*	**Will the patient need more than once-a-week FDA labeled dosing? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ units every 84 days**
❑**Ozempic injection (semaglutide)** *Once-a-week dosing is equivalent to 3 pens per 84 days or 1 pen per 28 days.*	**Will the patient need more than once-a-week FDA labeled dosing? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ units every 84 days**
❑**Rybelsus tablets (semaglutide)**	**Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ tabs every 90 days**
❑**Trulicity injection (dulaglutide)** *Once-a-week dosing is equivalent to 12 pens per 84 days or 4 pens per 28 days. Each pen provides dosing for 1 week.*	**Will the patient need more than once-a-week FDA labeled dosing? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ units every 84 days**
❑**Victoza injection (liraglutide)** *Once-a-day dosing is equivalent to 9 pens per 90 days or 3 pens per 30 days. Each pen provides dosing for up to 10 days.*	**Will the patient need more than once-a-day FDA labeled dosing? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ units every 90 days**

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

****Non-covered branded medications must go through prior authorization and the formulary exception process**

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of type 2 diabetes mellitus? ❑Yes ❑No
2. Will this medication be used in combination with other glucagon-like peptide-1 (GLP-1) receptor agonists? ❑Yes* ❑No
   If YES, please specify the medication: _____

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

3. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's hemoglobin A1c? _____ %

b. Does the patient have a history of fasting plasma glucose (FPG) greater than or equal to 126 milligrams per deciliter (mg/dL)? ❑Yes ❑No

c. Does the patient have a history of a 2-hour glucose of greater than or equal to 200 milligrams per deciliter (mg/dL) during an oral glucose tolerance test (OGTT)? ❑Yes ❑No

d. Does the patient have a history of symptoms of hyperglycemia (polyuria, polydipsia, polyphagia) or hyperglycemic crisis with a random plasma glucose greater than or equal to 200 milligrams per deciliter (mg/dL)? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has glycemic control improved or stabilized while on therapy? ❑Yes ❑No