Reference number(s)
REG 5496-C

Initial Prior Authorization with Quantity Limit
Antidiabetic Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist, Glucose-Dependent Insulinotropic Polypeptide (GIP) Receptor/Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist

Brand Name	Generic Name
Adlyxin	lixisenatide
Bydureon BCise	exenatide extended-release
Byetta	exenatide
Ozempic	semaglutide
Rybelsus	semaglutide
Trulicity	dulaglutide
Victoza	liraglutide

Glucose-Dependent Insulinotropic Polypeptide (GIP) Receptor and Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist

Brand Name	Generic Name
Mounjaro	tirzepatide

Indications

Adlyxin

FDA-approved Indications

Adlyxin is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- Adlyxin has not been studied in patients with chronic pancreatitis or a history of unexplained pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.
- Adlyxin should not be used in patients with type 1 diabetes mellitus.
- Adlyxin has not been studied in patients with gastroparesis and is not recommended in patients with gastroparesis.

Bydureon BCise

FDA-approved Indications

Bydureon BCise is indicated as an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients aged 10 years and older with type 2 diabetes mellitus.

Limitations of Use

- Bydureon BCise is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise because of the uncertain relevance of the rat thyroid C-cell tumor findings to humans.
- Bydureon BCise is not indicated for use in patients with type 1 diabetes mellitus.
- Bydureon BCise is an extended-release formulation of exenatide and should not be used with other products containing the active ingredient exenatide.
- Bydureon BCise has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.

Byetta

FDA-approved Indications

Byetta is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- Byetta is not indicated for use in patients with type 1 diabetes.
- Byetta contains exenatide and should not be used with other products containing the active ingredient exenatide. Byetta has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.

Mounjaro

FDA-approved Indications

Mounjaro is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- Mounjaro has not been studied in patients with a history of pancreatitis.
- Mounjaro is not indicated for use in patients with type 1 diabetes mellitus.

Ozempic

FDA-approved Indications

Ozempic is indicated:

- as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.
- to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease.
- to reduce the risk of sustained eGFR decline, end-stage kidney disease, and cardiovascular death in adults with type 2 diabetes mellitus and chronic kidney disease.

Rybelsus

FDA-approved Indications

Rybelsus is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- Rybelsus is not indicated for use in patients with type 1 diabetes mellitus.

Trulicity

FDA-approved Indications

Trulicity is indicated:

- as an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients 10 years of age and older with type 2 diabetes mellitus.
- to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus who have established cardiovascular disease or multiple cardiovascular risk factors.

Limitations of Use

- Trulicity has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.
- Trulicity should not be used in patients with type 1 diabetes mellitus.
- Trulicity has not been studied in patients with severe gastrointestinal disease, including severe gastroparesis and is therefore not recommended in these patients.

Compendial Uses

Advanced chronic kidney disease (CKD) in adults with type 2 diabetes mellitus[13]

Victoza

FDA-approved Indications

Victoza is indicated:

- as an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients aged 10 years and older with type 2 diabetes mellitus.
- to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease.

Limitations of Use

- Victoza should not be used in patients with type 1 diabetes mellitus.
- Victoza contains liraglutide and should not be coadministered with other liraglutide-containing products.

Compendial Uses

Advanced chronic kidney disease (CKD) in adults with type 2 diabetes mellitus[13]

Coverage Criteria

Type 2 Diabetes Mellitus

Authorization may be granted for a diagnosis of type 2 diabetes mellitus when ALL of the following criteria are met:

- The patient meets ONE of the following:
  - The patient has a history of an A1C greater than or equal to 6.5 percent. [ACTION REQUIRED: Documentation is required for approval.]
  - The patient has a history of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT). [ACTION REQUIRED: Documentation is required for approval.]
  - The patient has a history of symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dL. [ACTION REQUIRED: Documentation is required for approval.]
  - The patient has a history of a fasting plasma glucose (FPG) greater than or equal to 126 mg/dL [ACTION REQUIRED: Documentation is required for approval.] when the following criteria is met:
    - The patient fasted for at least 8 hours prior to the fasting plasma glucose (FPG) greater than or equal to 126 mg/dL.
- The patient meets ONE of the following:
  - If the request is for Adlyxin (lixisenatide), Bydureon BCISE (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide), Trulicity (dulaglutide), or Victoza (liraglutide), then the following criteria is met:
    - The patient has NOT been receiving a stable maintenance dose of a GLP-1 (glucagon-like peptide 1) Agonist for at least 3 months. [Note: Examples of GLP-1 Agonists are Adlyxin, Bydureon, Byetta, Ozempic, Rybelsus, Trulicity, Victoza].
  - If the request is for Mounjaro (tirzepatide), then the following criteria is met:
    - The patient has NOT been receiving a stable maintenance dose of the requested drug for at least 3 months.

Continuation of Therapy

Type 2 Diabetes Mellitus

Authorization may be granted for a diagnosis of type 2 diabetes mellitus when ALL of the following criteria are met:

- The patient meets ONE of the following:
  - The patient has a history of an A1C greater than or equal to 6.5 percent. [ACTION REQUIRED: Documentation is required for approval.]

  - The patient has a history of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT). [ACTION REQUIRED: Documentation is required for approval.]
  - The patient has a history of symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dL. [ACTION REQUIRED: Documentation is required for approval.]
  - The patient has a history of a fasting plasma glucose (FPG) greater than or equal to 126 mg/dL. [ACTION REQUIRED: Documentation is required for approval.] when the following criteria is met:
    - The patient fasted for at least 8 hours prior to the fasting plasma glucose (FPG) greater than or equal to 126 mg/dL.
- The patient meets ONE of the following:
  - If the request is for Adlyxin (lixisenatide), Bydureon BCISE (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide), Trulicity (dulaglutide), or Victoza (liraglutide) and the patient has been receiving a stable maintenance dose of a GLP-1 (glucagon-like peptide 1) Agonist for at least 3 months [Note: Examples of GLP-1 Agonists are Adlyxin, Bydureon, Byetta, Ozempic, Rybelsus, Trulicity, Victoza], then ONE of the following criteria is met:
    - The patient has demonstrated a reduction in A1C since starting GLP-1 Agonist therapy.
    - The patient has multiple cardiovascular risk factors AND the request is for Trulicity (dulaglutide).
    - The patient has established cardiovascular disease AND the request is for Trulicity (dulaglutide), Ozempic (semaglutide) or Victoza (liraglutide).
    - The patient has a diagnosis of chronic kidney disease AND the request is for Ozempic (semaglutide).
    - The patient has a diagnosis of advanced chronic kidney disease (CKD) (estimated glomerular filtration rate [eGFR] less than 30 mL/min/1.73m^2) AND the request is for Trulicity (dulaglutide) or Victoza (liraglutide).
  - If the request is for Mounjaro (tirzepatide) and the patient has been receiving a stable maintenance dose of the requested drug for at least 3 months, then the following criteria is met:
    - The patient has demonstrated a reduction in A1C since starting this therapy.

Quantity Limits Apply

PLEASE NOTE: Since manufacturer package sizes may vary, it is the discretion of the dispensing pharmacy to fill quantities per package size up to these quantity limits. In such cases the filling limit and day supply may be less than what is indicated.

The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing OR the duration of 21 days is used for a 28-day fill period and 63 days is used for an 84-day fill period to allow time for refill processing.

Drug	**Maximum Dosing**	**Package Size(s)**	**1 Month Limit** **3 Months Limit**
Adlyxin	20mcg daily	Starter pack - 2 pens (1 pen of 10mcg, 1 pen of 20mcg), 14 doses per pen, 3mL each Maintenance pack - 2 pens of 20mcg, 14 doses per pen, 3mL each	2 prefilled pens (6mL) / 21 days 6 prefilled pens (18mL) / 63 days
Bydureon BCise	2mg once weekly	Carton of 4 single-dose autoinjectors (2mg/0.85mL each)	4 auto-injectors (3.4mL) / 21 days 12 auto-injectors (10.2mL) / 63 days
Byetta	10mcg twice daily	5mcg dose, 60 doses, 1.2mL prefilled pen	1 prefilled pen (1.2mL) / 25 days 3 prefilled pens (3.6mL) / 75 days
Byetta	10mcg twice daily	10mcg dose, 60 doses, 2.4mL prefilled pen	1 prefilled pen (2.4mL) / 25 days 3 prefilled pens (7.2mL) / 75 days
Mounjaro	15mg once weekly	Carton of 4 pre-filled single-dose pens or 1 single-dose vial (0.5 mL each) of 2.5 mg/0.5 mL, 5 mg/0.5 mL, 7.5 mg/0.5 mL, 10 mg/0.5 mL, 12.5 mg/0.5 mL, 15 mg/0.5 mL	4 pre-filled single-dose pens or 4 single-dose vials (2 mL) / 21 days 12 pre-filled single-dose pens or 12 single-dose vials (6 mL) / 63 days
Ozempic	2mg once weekly	Carton of 1 pen (2mg/1.5mL)	1 prefilled pen (1.5mL) / 21 days 3 prefilled pens (4.5mL) / 63 days
Ozempic	2mg once weekly	Carton of 1 pen (2mg/3mL)	1 prefilled pen (3mL) / 21 days 3 prefilled pens (9mL) / 63 days
Ozempic	2mg once weekly	Carton of 1 pen (4mg/3mL)	1 prefilled pen (3mL) / 21 days 3 prefilled pens (9mL) / 63 days

Drug	Maximum Dosing	Package Size(s)	1 Month Limit 3 Months Limit
Ozempic	2mg once weekly	Carton of 1 pen (8mg/3mL)	1 prefilled pen (3mL) / 21 days 3 prefilled pens (9mL) / 63 days
Rybelsus (R2 formulation)	9mg once daily	1.5mg, 4mg, 9mg in bottles of 30 tablets	30 tablets / 25 days 90 tablets / 75 days
Rybelsus (R1 formulation)	14mg once daily	3mg, 7mg, 14mg in bottles of 30 tablets	30 tablets / 25 days 90 tablets / 75 days
Trulicity	4.5mg once weekly	0.75mg/0.5mL, 1.5mg/0.5mL, 3mg/0.5mL, 4.5mg/0.5mL in cartons of 4 single-dose pens (0.5mL each)	4 pens (2mL) / 21 days 12 pens (6mL) / 63 days
Victoza	1.8mg once daily	Package of 2 or 3 pens (18mg/3mL each)	3 prefilled pens (9mL) / 25 days 9 prefilled pens (27mL) / 75 days

Duration of Approval (DOA)

- 5496-C: DOA: 12 months

References

1. Adlyxin [package insert]. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; June 2022.
2. Bydureon BCise [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; May 2023.
3. Byetta [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; December 2022.
4. Mounjaro [package insert]. Indianapolis, IN: Lilly USA, LLC; July 2023.
5. Ozempic [package insert]. Plainsboro, NJ: Novo-Nordisk Inc.; January 2025.
6. Rybelsus [package insert]. Plainsboro, NJ: Novo-Nordisk Inc.; December 2024.
7. Trulicity [package insert]. Indianapolis, IN: Eli Lilly and Company; December 2022.
8. Victoza [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; July 2023.
9. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed March 11, 2024.
10. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 03/11/2024).
11. Blonde L, Umpierrez GE, Reddy SS et. al. American Association of Clinical Endocrinology Clinical Practice Guideline: Developing a Diabetes Mellitus Comprehensive Care Plan – 2022 Update. Endocr

Pract. 2022;28(10):923-1049.
12. Davies MJ, Aroda VR, Collins BS, et. al. Management of Hyperglycemia in Type 2 Diabetes, 2022. A Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). Diabetes Care. 2022;45(11):2753-2786.
13. American Diabetes Association Professional Practice Committee. American Diabetes Association, Standards of Care in Diabetes – 2024. Diabetes Care. 2024;47(Suppl. 1):S1-S322.
14. Samson SL, Vellank P, Blonde L, et. Al. American Association of Clinical Endocrinology Consensus Statement: Comprehensive Type 2 Diabetes Management Algorithm 2023 Update. Endocr Pract. 2023; 29: 305-340.

Document History

Written by: UM Development (VLS)

Date Written: 06/2022

Revised: (VLS) 07/2022 (no clinical changes), (VLS) 10/2022 (added Ozempic 2mg/3mL), 04/2023 (no clinical changes), 02/2024 (Added Adlyxin, Bydureon, Byetta, Rybelsus, Trulicity and Victoza), 04/2024 (Added approval pathway for advanced CKD for Ozempic, Trulicity and Victoza, Added Mounjaro via UM opt consolidation effort, updated document title), 10/2024 (added diagnosis confirmation requirements); (DFW) 12/2024 (added Rybelsus 1.5mg, 4mg, 9mg); VLS 01/2025 (added CKD indication for Ozempic)

Reviewed: Medical Affairs: (CHART) 06/30/2022, (CHART) 07/28/2022, (CHART) 10/27/2022, 04/27/2023, 02/15/2024, 04/25/2024, 11/07/2024, 12/19/2024, 02/20/2025

External Review: 08/2022(FYI), 12/2022 (FYI), 08/2023, 04/20204 (FYI), 09/2024, 12/2024, 02/2025 (FYI), 04/2025 (FYI)

CRITERIA FOR APPROVAL

1	Does the patient have a diagnosis of type 2 diabetes mellitus? [If Yes, then go to 2. If No, then no further questions.]	Yes	No
2	Does the patient have a history of an A1C greater than or equal to 6.5 percent? ACTION REQUIRED: If yes, the prescriber MUST submit chart notes or other documentation supporting a history of an A1C greater than or equal to 6.5 percent. _____ [If Yes, then go to 3. If No, then go to 4.] Tech Note: Leave response as answered by prescriber. Verification of chart note will be addressed in the next	Yes	No

	question.		
3	Have chart notes or other documentation supporting a history of an A1C greater than or equal to 6.5 percent been submitted to CVS Health? *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 11. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes or other documentation.	Yes	No
4	Does the patient have a history of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT)? ACTION REQUIRED: If yes, the prescriber MUST submit chart notes or other documentation supporting a history of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT). _____ [If Yes, then go to 5. If No, then go to 6.] Tech Note: Leave response as answered by prescriber. Verification of chart note will be addressed in the next question.	Yes	No
5	Have chart notes or other documentation supporting a history of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT) been submitted to CVS Health? *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 11. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes or other documentation.	Yes	No
6	Does the patient have a history of symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dL? ACTION REQUIRED: If yes, the prescriber MUST submit chart notes or other documentation supporting a history of symptoms of	Yes	No

	hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dL. _____ [If Yes, then go to 7. If No, then go to 8.] Tech Note: Leave response as answered by prescriber. Verification of chart note will be addressed in the next question.		
7	Have chart notes or other documentation supporting a history of symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dL been submitted to CVS Health? *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 11. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes or other documentation.	Yes	No
8	Does the patient have a history of a fasting plasma glucose (FPG) greater than or equal to 126 mg/dL? ACTION REQUIRED: If yes, the prescriber MUST submit chart notes or other documentation supporting a history of a fasting plasma glucose (FPG) greater than or equal to 126 mg/dL. _____ [If Yes, then go to 9. If No, then no further questions.] Tech Note: Leave response as answered by prescriber. Verification of chart note will be addressed in the next question.	Yes	No
9	Did the patient fast for at least 8 hours prior to the fasting plasma glucose (FPG) greater than or equal to 126 mg/dL? [If Yes, then go to 10. If No, then no further questions.]	Yes	No
10	Have chart notes or other documentation supporting a history of fasting plasma glucose (FPG) greater than or equal to 126 mg/dL been submitted to CVS Health? *ACTION REQUIRED: Submit supporting documentation*	Yes	No

	[If Yes, then go to 11. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes or other documentation.		
11	Is this request for Adlyxin (lixisenatide), Bydureon BCISE (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide), Trulicity (dulaglutide), or Victoza (liraglutide)? [If Yes, then go to 12. If No, then go to 22.]	Yes	No
12	Has the patient been receiving a stable maintenance dose of a GLP-1 (glucagon-like peptide 1) Agonist for at least 3 months? [Examples of GLP-1 Agonists are Adlyxin (lixisenatide), Bydureon BCISE (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide), Trulicity (dulaglutide), or Victoza (liraglutide)] [If Yes, then go to 13. If No, then go to 21.]	Yes	No
13	Has the patient demonstrated a reduction in A1C since starting GLP-1 (glucagon-like peptide 1) Agonist therapy? [If Yes, then go to 21. If No, then go to 14.]	Yes	No
14	Which drug is being requested? [Please check the drug being requested (applies to brand or generic unless otherwise noted).] [] Trulicity (dulaglutide) (If checked, go to 15) [] Ozempic (semaglutide) (If checked, go to 19) [] Victoza (liraglutide) (If checked, go to 17) [] Other (If checked, no further questions)		
15	Does the patient have established cardiovascular disease or multiple cardiovascular risk factors? [If Yes, then go to 21. If No, then go to 16.]	Yes	No

16	Does the patient have a diagnosis of advanced chronic kidney disease (CKD) (estimated glomerular filtration rate [eGFR] less than 30 mL/min/1.73m2)? [If Yes, then go to 21. If No, then no further questions.]	Yes	No
17	Does the patient have established cardiovascular disease? [If Yes, then go to 21. If No, then go to 18.]	Yes	No
18	Does the patient have a diagnosis of advanced chronic kidney disease (CKD) (estimated glomerular filtration rate [eGFR] less than 30 mL/min/1.73m2)? [If Yes, then go to 21. If No, then no further questions.]	Yes	No
19	Does the patient have established cardiovascular disease? [If Yes, then go to 21. If No, then go to 20.]	Yes	No
20	Does the patient have a diagnosis of chronic kidney disease (CKD)? [If Yes, then go to 21. If No, then no further questions.]	Yes	No
21	Does the patient require MORE than the plan allowance of any of the following: A) 2 prefilled pens of Adlyxin (lixisenatide) per 28 days, B) 4 autoinjectors of Bydureon BCISE (exenatide extended-release) per 28 days, C) 1 prefilled pen of Byetta (exenatide) per 30 days, D) 1 prefilled pen of Ozempic (semaglutide) per 28 days, E) 30 tablets of Rybelsus (semaglutide) per 30 days, F) 4 pens of Trulicity (dulaglutide) per 28 days, G) 3 prefilled pens of Victoza (liraglutide) per 30 days? [No further questions] RPh Note: If yes, then deny and enter a partial approval per Quantity Limit Chart.	Yes	No
22	Has the patient been receiving a stable maintenance dose of the requested drug for at least 3 months? [If Yes, then go to 23. If No, then go to 24.]	Yes	No
23	Has the patient demonstrated a reduction in A1C since starting this therapy? [If Yes, then go to 24. If No, then no further questions.]	Yes	No

24	Does the patient require MORE than the plan allowance of 4 single-dose pens or single-dose vials of Mounjaro (tirzepatide) per 28 days? [No further questions] RPh Note: If yes, then deny and enter a partial approval per Quantity Limit Chart.	Yes	No

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS**
1.	Go to 2	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered use is for type 2 diabetes. Your plan does not cover the drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis]
2.	Go to 3	Go to 4	
3.	Go to 11	Deny	Your plan only covers this drug when A) your A1C is sent to us, and your test results are in a certain range (history of A1C greater than or equal to 6.5 percent), B) your 2-hour plasma glucose (PG) during oral glucose tolerance test (OGTT) is sent to us, and your results are in a certain range (history of 2-hour PG greater than or equal to 200 mg/dL), C) your random plasma glucose is sent to us, and your test results are in a certain range (history of random plasma glucose greater than or equal to 200 mg/dL with symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis), or D) your fasting plasma glucose (FPG) is sent to us, and your results are in a certain range (history of FPG greater than or equal to 126 mg/dL). We denied your request because: A) We did not receive your results, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any

			new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/Test]
4.	Go to 5	Go to 6	
5.	Go to 11	Deny	Your plan only covers this drug when A) your A1C is sent to us, and your test results are in a certain range (history of A1C greater than or equal to 6.5 percent), B) your 2-hour plasma glucose (PG) during oral glucose tolerance test (OGTT) is sent to us, and your results are in a certain range (history of 2-hour PG greater than or equal to 200 mg/dL), C) your random plasma glucose is sent to us, and your test results are in a certain range (history of random plasma glucose greater than or equal to 200 mg/dL with symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis), or D) your fasting plasma glucose (FPG) is sent to us, and your results are in a certain range (history of FPG greater than or equal to 126 mg/dL). We denied your request because: A) We did not receive your results, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/Test]
6.	Go to 7	Go to 8	
7.	Go to 11	Deny	Your plan only covers this drug when A) your A1C is sent to us, and your test results are in a certain range (history of A1C greater than or equal to 6.5 percent), B) your 2-hour plasma glucose (PG) during oral glucose tolerance test (OGTT) is sent to us, and your results are in a certain range (history of 2-hour PG greater than or equal to 200 mg/dL), C) your random plasma glucose is sent to us, and your test results are in a certain range (history of random plasma

			glucose greater than or equal to 200 mg/dL with symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis), or D) your fasting plasma glucose (FPG) is sent to us, and your results are in a certain range (history of FPG greater than or equal to 126 mg/dL). We denied your request because: A) We did not receive your results, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/Test]
8.	Go to 9	Deny	Your plan only covers this drug when A) your A1C is sent to us, and your test results are in a certain range (history of A1C greater than or equal to 6.5 percent), B) your 2-hour plasma glucose (PG) during oral glucose tolerance test (OGTT) is sent to us, and your results are in a certain range (history of 2-hour PG greater than or equal to 200 mg/dL), C) your random plasma glucose is sent to us, and your test results are in a certain range (history of random plasma glucose greater than or equal to 200 mg/dL with symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis), or D) your fasting plasma glucose (FPG) is sent to us, and your results are in a certain range (history of FPG greater than or equal to 126 mg/dL). We denied your request because: A) We did not receive your results, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/Test]
9.	Go to 10	Deny	Your plan only covers this drug when you have a history of fasting plasma glucose (FPG) within a certain range after an 8 hour fast. We denied your request because your test result did not show you

			fasted for at least 8 hours. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Labs/test - FPG 8-hour fast]
10.	Go to 11	Deny	Your plan only covers this drug when A) your A1C is sent to us, and your test results are in a certain range (history of A1C greater than or equal to 6.5 percent), B) your 2-hour plasma glucose (PG) during oral glucose tolerance test (OGTT) is sent to us, and your results are in a certain range (history of 2-hour PG greater than or equal to 200 mg/dL), C) your random plasma glucose is sent to us, and your test results are in a certain range (history of random plasma glucose greater than or equal to 200 mg/dL with symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis), or D) your fasting plasma glucose (FPG) is sent to us, and your results are in a certain range (history of FPG greater than or equal to 126 mg/dL). We denied your request because: A) We did not receive your results, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/Test]
11.	Go to 12	Go to 22	
12.	Go to 13	Go to 21	
13.	Go to 21	Go to 14	
14.	1=15 ;2=19 ;3=17		Your plan only covers this drug when it works well for you. We reviewed information we had. Your request has been denied because the drug did not work well for you, or you do not have

	;4=Deny		heart disease. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Continuation: Efficacy]
15.	Go to 21	Go to 16	
16.	Go to 21	Deny	Your plan only covers this drug when: A) It works well for you, B) You have risk factors for heart disease, C) You have advanced kidney disease, or D) You have heart disease. We reviewed information we had. Your request has been denied because A) The drug did not work well for you, B) You do not have risk factors for heart disease, C) You do not have advanced kidney disease, or D) You do not have heart disease. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Continuation: Efficacy, Diagnosis - Trulicity]
17.	Go to 21	Go to 18	
18.	Go to 21	Deny	Your plan only covers this drug when: A) It works well for you, B) You have advanced kidney disease, or C) You have heart disease. We reviewed information we had. Your request has been denied because A) The drug did not work well for you, B) You do not have advanced kidney disease, or C) You do not have heart disease. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Continuation: Efficacy, Diagnosis - Victoza]
19.	Go to 21	Go to 20	

20.	Go to 21	Deny	Your plan only covers this drug when: A) It works well for you, B) You have chronic kidney disease, or C) You have heart disease. We reviewed information we had. Your request has been denied because A) The drug did not work well for you, B) You do not have chronic kidney disease, or C) You do not have heart disease. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Continuation: Efficacy, Diagnosis - Ozempic]
21.	[Please select appropriate denial close option. For the denial verbiage, only include the requested drug. Remove all other drugs from verbiage.]. Deny	[PA Approved for 12 months. See Quantity Limit Chart.]. Approve, 12 Months	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have approved your request for this drug up to the amount your plan covers [A) 2 prefilled pens of Adlyxin per 28 days; B) 4 autoinjectors of Bydureon BCISE per 28 days; C) 1 prefilled pen of Byetta per 30 days; D) 1 prefilled pen of Ozempic per 28 days; E) 30 tablets of Rybelsus per 30 days; F) 4 pens of Trulicity per 28 days; G) 3 prefilled pens of Victoza per 30 days]. Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]
22.	Go to 23	Go to 24	
23.	Go to 24	Deny	Your plan only covers this drug when it works well for you. We reviewed information we had. Your request has been denied because the drug did not work well for you, or you do not have heart disease. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Continuation: Efficacy]

24.	Deny	[PA Approved for 12 months. See Quantity Limit Chart.]. Approve, 12 Months	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have approved your request for this drug up to the amount your plan covers (4 single-dose pens or single-dose vials per 28 days). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial - Mounjaro]