GLUCAGON-LIKE PEPTIDE-1 (GLP-1) RECEPTOR AGONIST: OZEMPIC, RYBELSUS, TRULICITY, liraglutide, Mounjaro

If a claim is submitted with an ICD 10 diagnosis code from the approved list of ICD 10 codes, indicating type 2 diabetes mellitus under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the prescription does not have an appropriate ICD 10 code, then a PA is required as outlined below.

COVERAGE CRITERIA

Initial Approval

The requested drug will be covered with prior authorization when the following criteria are met:

- The member has a diagnosis of type 2 diabetes mellitus as *documented* and provided in the Medical Record confirmed by one or more of the following:
    - History of an A1C greater than or equal to 6.5 percent OR
    - History of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT) OR
    - 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 OR
    - History of a fasting plasma glucose (FPG) greater than or equal to 126 mg/dL and the following criteria is met:
        - The member fasted for at least 8 hours prior to the fasting plasma glucose (FPG) greater than or equal to 126 mg/dL

AND

- The member has had a trial of at least a 90 day supply of metformin within the past 360 days under a prescription benefit administered by CVS Caremark and had inadequate treatment response (documentation required)

OR

- An intolerance or contraindication to metformin (documentation required)

OR

- The request is for Ozempic (semaglutide), Trulicity (dulaglutide), or Victoza (liraglutide) **AND** the member has established cardiovascular disease (documentation required)

OR

- The request is for Trulicity (dulaglutide) **AND** the member has multiple cardiovascular risk factors (documentation required)

OR

- The member requires combination therapy **AND** has an A1c (hemoglobin A1c) of 7.5 percent or greater (documentation required)

OR

- The request is for Ozempic **AND** the member has a diagnosis of chronic kidney disease (documentation required)

OR

- The request is for Trulicity or Victoza (liraglutide) **AND** the member has a diagnosis of advanced chronic kidney disease (CKD) (estimated glomerular filtration rate [eGFR] less than 30mL/min/1.73m2) (documentation required)

Continuation of Therapy

The member has a diagnosis of type 2 diabetes mellitus as *documented* and provided in the Medical Record confirmed by one or more of the following:

- History of an A1C greater than or equal to 6.5 percent OR
- History of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT) OR
- 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 OR
- History of a fasting plasma glucose (FPG) greater than or equal to 126 mg/dL and the following criteria is met:
    - The member fasted for at least 8 hours prior to the fasting plasma glucose (FPG) greater than or equal to 126 mg/dL

AND

- The member has been receiving the requested drug for at least 3 months (samples are not considered)

AND

- The member has demonstrated a reduction in A1c (hemoglobin A1c) since starting this therapy (documentation required)

Approval is for 1 year.