GLUCAGON-LIKE PEPTIDE-1 (GLP-1) RECEPTOR AGONIST: ADLYXIN, BYDUREON, BYDUREON BCISE, BYETTA, MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY, VICTOZA

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

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.

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 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)

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)

Approval is for 1 year.