IOWA Health and Human Services

Request for Prior Authorization Incretin Mimetics for Non-Diabetes Indications

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved for compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warning and precautions, drug interactions, and use in specific populations; and
2. Patient is ≥ 45 years of age; and
3. Patient has been screened for and does not have type 1 or type 2 diabetes mellitus (attach current lab results, obtained within 6 months of request, documenting an A1C < 6.5% or a fasting plasma glucose < 126 mg/dL); and
4. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
    a. Patient has established CVD with history of one of the following (attach chart notes documenting diagnosis):
        i. Prior myocardial infarction (MI);
        ii. Prior stroke (ischemic or hemorrhagic);
        iii. Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; and
    b. Patient has a baseline body mass index (BMI) ≥ 27kg/m^2, obtained within 6 months of request; and
    c. Patient has been evaluated for cardiovascular standard of care treatment; and
    d. For Wegovy dosing:
        i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
        ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; and
5. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
6. The requested agent will not be used in combination with other incretin mimetics.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose, will be considered when:

1. The requested drug will be used to reduce the risk of MACE; and
    a. Patient does not have type 1 or type 2 diabetes; and

b. Patient has been evaluated for cardiovascular standard of care treatment; and

c. For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg weekly is requested; and

2. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
3. The requested agent will not be used in combination with other incretin mimetics.

Non-Preferred

☐ Wegovy

Strength	**Usage Instructions**	**Quantity**	**Day's Supply**
____________	____________________________	____________	______________

Diagnosis:____

Initial Requests:

Does patient have Type 1 or Type 2 Diabetes (attach lab results documenting current A1C or fasting plasma glucose)? ☐ Yes ☐ No

Patient has established CVD documented by one of the following (attach chart notes documenting diagnosis):

☐ Prior myocardial infarction
☐ Prior stroke (ischemic or hemorrhagic)
☐ Symptomatic PAD, as evidenced by:
 ☐ Intermittent claudication with ABI less than 0.85 (at rest), or
 ☐ Peripheral arterial revascularization procedure, or
 ☐ Amputation due to atherosclerotic disease

Provide patient's baseline BMI: ______________________________ Date Obtained: ________________

Has patient been evaluated for cardiovascular standard of care treatment? ☐ Yes ☐ No

Will patient be using medication in combination with a reduced calorie diet and increased physical activity? ☐ Yes ☐ No

Will the requested agent be used in combination with other incretin mimetics? ☐ Yes ☐ No

Renewal Requests:

Does patient have Type 1 or Type 2 Diabetes (attach lab results documenting current A1C or fasting plasma glucose)? ☐ Yes ☐ No

Has patient been evaluated for cardiovascular standard of care treatment? ☐ Yes ☐ No

Patient continues to use medication in combination with a reduced calorie diet and increased physical activity? ☐ Yes ☐ No

Will the requested agent be used in combination with other incretin mimetics? ☐ Yes ☐ No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*