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 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
3. 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:
        i. Patient is ≥ 45 years of age; and
        ii. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
        iii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; or
4. Patient has a diagnosis of moderate to severe obstructive sleep apnea (OSA); and
    a. Patient has a baseline BMI ≥ 30kg/m$^2$; and
    b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI) ≥ 15 events per hour, as documented by a polysomnography (PSG) or at-home sleep study (document AHI); and
    c. For Zepbound:
        i. Patient meets the FDA approved age for OSA; and
        ii. Initiation and escalation dosages will be permitted up to a maximum of 20 weeks prior to reaching the recommended maintenance dosage of 10 mg to 15 mg once weekly; and

iii. Maintenance dosages other than 10 mg to 15 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 has been evaluated for cardiovascular standard of care treatment; and
    b. For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg weekly is requested; or
2. The requested drug will be used to treat moderate to severe OSA; and
    a. Documentation of a positive response to therapy is provided; and
    b. The maintenance dose is requested and maintained (Zepbound 10 mg to 15 mg once weekly); and
3. Patient does not have type 1 or type 2 diabetes; and
4. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
5. The requested agent will not be used in combination with other incretin mimetics.

| **Preferred** | **Non-Preferred** | | |
|---|---|---|---|
| ☐ Zepbound | ☐ 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

**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

**Requests for Wegovy:**

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

☐ Prior myocardial infarction

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- ☐ 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

**Requests for Zepbound:**

**Provide patient's baseline BMI:** _____ Date Obtained: _____

**Does patient have a recent (within prior three years) apnea/hypopnea index (AHI) ≥ 15 events per hour, as documented by a PSG or at-home sleep study?**

☐ Yes Document AHI: _____ ☐ No

**Renewal Requests:**

**Does patient have Type 1 or Type 2 Diabetes (attach lab results documenting current A1C or fasting plasma glucose)?** ☐ 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

**Wegovy:**

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

**Zepbound:**

**Document positive response to therapy:** _____

_____

***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.*