TEXAS MEDICAID
Clinical Edit Prior Authorization
GLP-1 RECEPTOR AGONISTS

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 18 years of age?
   - ☐ Yes (Go to #3)
   - ☐ No (And request is for VICTOZA, go to #2)
   - ☐ No (And request is for any agent other than VICTOZA, deny)

2. Is the client greater than or equal to (≥) 10 years of age?
   - ☐ Yes (Go to #3)
   - ☐ No (Deny)

3. Does the client have a diagnosis of Type 2 Diabetes in the last 365 days?
   - ☐ Yes (Go to #4)
   - ☐ No (Deny)

4. Does the client have a history of an oral antidiabetic agent for 14 days in the last 365 days?

   Examples of oral antidiabetic agents include alogliptin (NESINA), AVANDIA, FARXIGA, glimepiride (AMARYL), glipizide (GLUCOTROL (XL)), glyburide (GLYNASE), INVOKANA, JANUVIA, JARDIANCE, metformin (GLUCOPHAGE, RIOMET), nateglinide (STARLIX), ONGLYZA, pioglitazone (ACTOS), repaglinide (PRANDIN), TRADJENTA, and others.
   - ☐ Yes (Go to #6)
   - ☐ No (Go to #5)

5. Does the client have a history of the requested medication for 14 days in the last 365 days?
   - ☐ Yes (Go to #6)
   - ☐ No (Deny)

6. Does the client have a history of ONE (1) of the following in the last 730 days?
   - Chronic Kidney Disease (stage IV or V)
   - End-Stage Renal Disease (ESRD)
   - Gastroparesis
   - Pancreatitis

   - ☐ Yes (Deny)
   - ☐ No (Go to #7)

7. Does the client have a history of End-Stage Renal Disease (ESRD) services (CPT codes) in the last 730 days?
   - ☐ Yes (Deny)
   - ☐ No (Go to #8)

8. Does the client have a history of a hemoglobin A1c (HbA1c) test in the last 180 days?
   - ☐ Yes (Approve – 365 days)
   - ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.