GLP-1 RECEPTOR AGONISTS FOR ALL INDICATIONS PRIOR AUTHORIZATION

Submit completed form by fax to: (573) 636-6470

Please print or type. All information must be supplied or the request will not be processed. Attach another sheet if additional documentation is required. For drug specific requirements or questions, call (800) 392-8030. **Submit completed form by fax to (573) 636-6470** or by mail: ATTN: Drug Prior Authorization, MO HealthNet Division, PO Box 4900, Jefferson City MO 65102-4900.

Participant Information

Participant Name	Date of Birth	Participant MO HealthNet Number

Diagnosis	ICD-10 Code

Preferred GLP-1 Receptor Agonists

Diabetes – Participant must have a diagnosis of diabetes mellitus

☐ Byetta ☐ Mounjaro ☐ Ozempic ☐ Trulicity ☐ Victoza

Specify strength, dosage form and administration directions:

Obesity

☐ Zepbound (tirzepatide) ☐ Foundayo (orforglipron)	Body Mass Index (BMI)	Date BMI Measured

Specify strength, dosage form and administration directions:

Patients established on Zepbound prior to MO HealthNet coverage must provide documentation of Body Mass Index (BMI) at start of therapy along with current BMI. Method of payment and three (3) most recent fill dates will also be required.

Choose one (1) of the following and provide documentation as necessary:

☐	Concurrent therapy with an antipsychotic	
☐	Participant is 12-17 years of age and BMI ≥ 95th percentile standardized for age and sex	
☐	Participant is ≥ 18 years of age and BMI ≥ 30 kg/m^2	
☐	Participant is ≥ 18 years of age and BMI ≥ 27 kg/m^2 with documentation of at least one (1) weight-related comorbid condition. Submit supporting documentation.	Co-Morbid Condition
☐	Participant is ≥ 18 years of age and has a diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) demonstrating F2 or F3 fibrosis. Must submit recent liver biopsy or noninvasive techniques confirming diagnosis.	

Non-Preferred GLP-1 Receptor Agonists

Diabetes – Participant must have a diagnosis of diabetes mellitus

☐ Bydureon BCise ☐ Exenatide ☐ Liraglutide (generic Victoza) ☐ Rybelsus ☐ Soliqua ☐ Xultophy

Requests for Soliqua and Xultophy require reason why participant cannot utilize a preferred GLP-1 Receptor Agonist along with a preferred long-acting insulin. This should be submitted as a separate document.

Specify strength, dosage form and administration directions:

Has the patient had a therapeutic trial of metformin? ☐ Yes ☐ No
If yes, list dates. If no, provide an explanation.

MO HealthNet requires a therapeutic trial of three (3) preferred agents for three (3) months each prior to a request for a non-preferred agent. Requests for non-preferred agents must be accompanied by progress notes documenting the reason each of the preferred agents were discontinued.
List trial dates for each preferred medication.

Preferred Agent	Trial Date
Preferred Agent	Trial Date
Preferred Agent	Trial Date

Obesity

Wegovy for the reduction of excess body weight or maintenance of weight reduction long term is not covered by MO HealthNet.

☐ Wegovy (semaglutide)	Specify strength, dosage form and administration directions:

There are two (2) diagnoses for which MO HealthNet participants are covered for Wegovy. Choose the appropriate diagnosis below. Complete the additional questions and submit the required documentation for the appropriate diagnosis chosen.

☐ **Reduction of the risk major adverse cardiovascular events (MACE)**

☐ Lack of diagnosis of diabetes as evidenced by documented Hemoglobin A1C within past 3 months < 6.5 demonstrating lack of diabetes mellitus and lack of history of any anti-diabetic pharmaceutical therapy attached

☐ Documentation indicating participant is ≥ 45 years of age and has a BMI ≥ 27 kg/m^2 attached

☐ Choose the participant's diagnosis and submit documentation of one (1) of the below:

- ☐ Myocardial infarction
- ☐ Stroke
- ☐ Symptomatic peripheral arterial disease, as evidenced by one of the following:
  - Intermittent claudication with ABI < 0.85 (at rest);
  - Peripheral arterial revascularization procedure; **OR**
  - Amputation due to ASCVD

☐ Documentation of all current medications for the diagnosis listed above attached

☐ **Noncirrhotic metabolic dysfunction associated steatohepatitis (MASH) demonstrating F2 or F3 fibrosis**

☐ Recent liver biopsy or noninvasive techniques confirming diagnosis attached

☐ Lack of diagnosis of diabetes as evidenced by documented Hemoglobin A1C within past 3 months < 6.5 demonstrating lack of diabetes mellitus and lack of history of any anti-diabetic pharmaceutical therapy attached

Initial approval for Wegovy is for four (4) weeks only. Subsequent approvals will be required for each dose during the titration process. All approvals will be for only four (4) weeks to allow for monitoring of proper dose escalation until maintenance therapy dosing is achieved (at least 1.7 mg/dose). An additional four (4) weeks for each dose in the titration process may be approved one time with documentation of intolerable adverse effects during dose escalation.

Prescriber Information

Prescriber Name and Specialty	Prescriber Provider NPI
Prescriber Telephone Number	Prescriber Other Contact Information

Person Completing Form Information

Name of Person Completing Form	Title and Credentials
Telephone Number	Fax Number
Signature of Person Completing Form	Date