

## GLP-1 Receptor Agonist Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.**

1. Patient information	2. Physician information
Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
<input type="checkbox"/> Adlyxin (Lixisenatide) <input type="checkbox"/> Bydureon (Exenatide Microspheres) <input type="checkbox"/> Byetta (Exenatide) <input type="checkbox"/> Ozempic (Semaglutide) <input type="checkbox"/> Soliqua (Insulin Glargine/Lixisenatide) <input type="checkbox"/> Trulicity (Dulaglutide) <input type="checkbox"/> Victoza (Liraglutide) <input type="checkbox"/> Xultophy (Insulin Degludec/Liraglutide)	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>	Specify: <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>
<b>7. Diagnosis:</b> _____			

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of type II diabetes in the last 365 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of an oral antidiabetic agent for 14 days in the last 365 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of the requested medication for 14 days in the last 365 days?

- Yes  No Does the patient have a history of end-stage renal disease (ESRD), chronic kidney disease (stage IV and V), pancreatitis or gastroparesis in the last 730 days?
- Yes  No Does the patient have a history of ESRD services (CPT® codes) in the last 730 days?  
If yes, provide CPT code: \_\_\_\_\_
- Yes  No Does the patient have a history of an HbA1c test in the last 180 days?
- Yes  No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
- Yes  No Patient has a documented allergy or contraindication to preferred agents in this class.
- Yes  No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs>.

**9. Physician signature**

\_\_\_\_\_  
Prescriber or authorized signature

\_\_\_\_\_  
Date

PA of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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