NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT
Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RA)

(NOTE: GLP-1 RA approved subsequent to this bulletin shall be subject to these criteria.)
The first PA will be effective for 6 months; thereafter, a new PA must be requested every 12 months.

Brand Name	Generic Name
Byetta®	Exenatide
Bydureon®	Exenatide Extended-Release
Victoza®	Liraglutide
Tanzeum®	Albiglutide
Trulicity®	Dulaglutide

PRESCRIBING PROVIDER:

Name: _____

Phone #: (_____)-_____-_____

Fax #: (_____)-_____-_____

NPI #: _____

DEA #: _____

MEDICAID RECIPIENT:

Name: _____

Medicaid # ☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

(Note: patient must be 16 years or older).

Male **Female**

PARTICIPATING PHARMACY:

Name: _____

Phone #: (_____)-_____-_____

Request Date: _____

Fax #: (_____)-_____-_____

Requested Drug Name: **Strength:** **Administration Schedule:**

INCRETIN MIMETIC AGENT CRITERIA:

1. **What is patient's current HbA1C level?** _____

   (Attach a copy of lab report of recent (within the last six months) HbA1C)

2. **Metformin remains first-line for type-2 diabetes.**

   a. Has patient had an adequate trial with metformin and not achieved treatment goal? ☐Yes ☐No

   b. Is patient intolerant to metformin? ☐Yes ☐No

3. List the patient's current glucose control agents*: (Compliance will be verified utilizing Medicaid claims data)

Drug Name and strength	Dosing Schedule

Byetta®, Tanzeum®, and Victoza® requests will be denied for patients concurrently taking any insulin other than basal insulin. Trulicity® requests will be denied is used with basal insulin. Bydureon® requests will be denied for patients concurrently taking insulin.

4. For what specific reason is this GLP-1 RA agent being requested for this patient?

Prescriber Signature: _____ **Date:** _____

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.) **Please note:** Nebraska Total Care request chart documentation to verify the above information.

Submit requests to: Envolve Pharmacy Solutions Fax: 1-866-399-0929 Tel: 1-844-330-7852