Ozempic (semaglutide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Type II diabetes** ☐ **Type II diabetes with Chronic kidney disease(CKD)** ☐ **Type II diabetes with established cardiovascular disease** ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Was the patient's most recent HbA1c in the past 6 months or prior to starting the requested medication 7.0% or greater? □ **Yes** □ **No** ***Documentation of HbA1c level required.***

Is the patient currently taking any of the following medications? □ **Yes** □ **No**
If yes, please select:

- □ **Janumet/Janumet XR (sitagliptin/metformin)**
- □ **Januvia (sitagliptin)**
- □ **Jentadueto/Jentadueto XR (linagliptin/metformin)**
- □ **Kazano (alogliptin/metformin)**
- □ **Kombiglyze XR (saxagliptin/metformin)**
- □ **Nesina (alogliptin)**
- □ **Onglyza (saxagliptin)**
- □ **Oseni (alogliptin/pioglitazone)**
- □ **Tradjenta (linagliptin)**
- □ **Glyxambi (empagliflozin/linagliptin)**
- □ **Seglujan (ertugliflozin/sitagliptin)**
- □ **Qtern (dapagliflozin/saxagliptin)**

If the patient is taking any of the above medications, will concomitant therapy with those medications be discontinued? □ **Yes** □ **No**

For diagnosis of Type II diabetes with no comorbid condition listed above:
Has the patient tried or is the patient currently taking metformin? □ **Yes** □ **No** ***Documentation required.***

Has treatment with metformin been avoided due to lactic acidosis or elevated liver enzymes? □ **Yes** □ **No** ***Documentation required.***

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Is the patient's estimated glomerular filtration rate (GFR) less than or equal to 45 mL/min/1.73 m2? □ Yes □ No *Documentation of GFR required.*

Does the patient currently have a serum creatinine level exceeding 1.8 mg/dL or an estimated GFR less than 30 mL/min/1.73 m^2? □ Yes □ No *Documentation required.*

Does the patient have advanced liver disease with at least one of the following? □ Yes □ No *Documentation required.*
If yes, please select:
- **□ Ascites**
- **□ Cirrhosis**
- **□ Hepatic encephalopathy**
- **□ Portal hypertension**

Has the patient had a 3-month trial with either generic exenatide or liraglutide ? □ Yes □ No *Documentation required.*

If patient has used either generic exenatide or liraglutide, did patient reach their HbA1C goal of less than 7%?□ Yes □ No *Documentation required.*

Does patient have an absolute contraindication to both generic exenatide AND liraglutide? □ Yes □ No *Documentation required.*

For diagnosis of Type II diabetes with established cardiovascular disease, answer the following:
Is patient 50 years of age or older with established cardiovascular disease characterized by at least one of the following? □ Yes □ No *Please submit chart documentation*.
- **□ History of MI or stroke or transient ischemic attack**
- **□ History of unstable angina with ECG changes**
- **□ History of coronary revascularization procedure**
- **□ History of carotid revascularization procedure**
- **□ History of peripheral revascularization procedure**
- **□ History of symptomatic coronary heart disease documented by positive stress test, or cardiac imaging**
- **□Patient has more than 50% stenosis on angiography or imaging of coronary, carotid or lower extremities arteries**
- **□Patient has asymptomatic cardiac ischemia documented by positive nuclear imaging test or exercise test or stress echo or any cardiac imaging**
- **□Patient has chronic heart failure NYHA class II or III**
- **□Chronic renal impairment documented by eGFR below 60ml/min/1.73m^2 per modification of diet in renal disease(MDRD)**

Is patient 60 years of age or older AND has at least 1 or more of the following risk factors? □ Yes □ No *Please submit chart documentation*.
- **□ Persistent microalbuminuria (30.299mg/g) or proteinuria**
- **□ Hypertension and left ventricular hypertrophy by ECG or imaging**
- **□ Left ventricular systolic or diastolic dysfunction by imaging**

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□ **Ankle/brachial index less than 0.9**

For the diagnosis of Type II diabetes with chronic kidney disease(CKD), please answer the following:
Is patient's most recent HgbA1c in the past 6months, prior to starting the requested GLP-1 product less than or equal to 10%(documentation required)? □ Yes □ No *Please submit chart documentation*.

Has the patient had renal impairment for at least 3-months □ Yes □ No *Please submit chart all lab reports documenting renal impairment.*
Defined either by(documentation required):
□ Serum creatinine-based eGFR greater than or equal to 50 and less than or equal to 75 mL/min/1.73 m^2 (CKD-EPI) and UACR greater than 300 and less than 5000 mg/g, OR
□ Serum creatinine-based eGFR greater than or equal to 25 and less than 50 mL/min/1.73 m^2 (CKD-EPI) and UACR greater than 100 and less than 5000 mg/g

Has patient been on treatment and stable for at least 4 weeks prior to starting Ozempic(semaglutide) with the maximum labelled or tolerated dose of a renin-angiotensin-aldosterone system (RAAS) blocking agent including an angiotensin converting enzyme (ACE) inhibitor or an angiotensin II receptor blocker (ARB)? □ Yes □ No *Please submit chart documentation*.

Is treatment with a renin-angiotensin-aldosterone system (RAAS) blocking agent including an angiotensin converting enzyme (ACE) inhibitor or an angiotensin II receptor blocker (ARB contraindicated or not tolerated? □ Yes □ No *Please submit chart documentation*.

Is patient presently classified as being in New York Heart Association (NYHA) Class IV heart failure? □ Yes □ No *Please submit chart documentation*.

Is patient on current (or within 90 days) chronic or intermittent haemodialysis or peritoneal dialysis? □ Yes □ No *Please submit chart documentation*.

Does patient have a congenital or hereditary kidney diseases including polycystic kidney disease, autoimmune kidney diseases including glomerulonephritis or congenital urinary tract malformations? □ Yes □ No *Please submit chart documentation*.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

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ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
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St. Paul, MN 55164-0811
Phone: 877-228-7909