GLP-1 Agonists and Combination Products
Bydureon Bcise (exenatide)
Ozempic (semaglutide)
Rybelsus (semaglutide) tablets
Soliqua (insulin glargine and lixisenatide)
Xultophy (insulin degludec and liraglutide)
Effective January 1, 2021

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Glucagon-like peptide-1 (GLP-1) receptor agonist act on the same receptor as the endogenous hormone incretin, which increases glucose-dependent insulin secretion, decreases inappropriate glucagon secretion, and slows gastric emptying. Increases first- and second-phase insulin secretion.

No PA	PA required
Bydureon® (exenatide extended-release pen)	Bydureon BCise® (exenatide extended-release auto-injection)
Byetta® (exenatide) §	Ozempic® (semaglutide injection)
Trulicity® (dulaglutide) [PD]	Rybelsus® (semaglutide tablet)
Victoza® (liraglutide)	Soliqua® (insulin glargine/lixisenatide)
	Xultophy® (insulin degludec/liraglutide)

[PD] Preferred Drug. A trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class. Please note, for Trulicity® (dulaglutide) and GLP-1 receptor agonists, a trial with a preferred agent is not required prior to approval of a non-preferred agent.
§ Brand Preferred over generic equivalents. In general, requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

Coverage Guidelines

Authorizations requests will be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

1. The member has a diagnosis of type 2 Diabetes Mellitus
2. **ONE** of the following:
    a. Inadequate response (defined as at least 90 days of therapy within a 120-day time period) to metformin used in combination with **ONE** of the following:
        i. Bydureon (exenatide extended-release pen)
        ii. Byetta(exenatide)
        iii. Trulicity (dulaglutide)
        iv. Victoza (liraglutide)
    b. **BOTH** of the following:
        i. Adverse reaction, inadequate response (defined as at least 90 days of therapy within a 120-day time period) or contraindication to metformin
        ii. Inadequate response (defined as at least 90 days of therapy within a 120-day time period) to **ONE** of the following:
            1. Bydureon (exenatide extended-release pen)
            2. Byetta (exenatide)
            3. Trulicity (dulaglutide)
            4. Victoza (liraglutide)
    c. **BOTH** of the following:
        i. Inadequate response (defined as at least 90 days of therapy within a 120-day time period), adverse reaction or contraindication to metformin‡
        ii. Contraindication to **ALL** of the following:
            1. Bydureon® (exenatide extended-release pen)
            2. Byetta® (exenatide)
            3. Trulicity® (dulaglutide)
            4. Victoza® (liraglutide)

NOTE: *Requests for Rybelsus® (semaglutide tablet) may be approved in patients without a trial of a GLP-1 agonist if it is documented that the member is not a candidate for injectable formulations and if an alternative second line agent is used in combination with metformin (e.g., DPP-IV, SGLT2, TZD, sulfonylurea or insulin) in place of the GLP-1 agonist in 2a to 2c above.*

Limitations

1. Initial approval and reauthorizations will be granted for 12 months.
2. The following quantity limits apply:

Bydureon Bcise	4 autoinjectors per 30 days
Ozempic	2 pens per 30 days
Soliqua	6 prefilled pens per 30 days
Rybelsus	30 tablets per 30 days
Xultophy	1 carton (5 prefilled) pens per 30 days

References

Review History

09/30/2020 – Updated; Match Masshealth partial unified formulary requirements for implementation on 1/1/21

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.