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.

<table>
<thead>
<tr>
<th>No PA</th>
<th>PA required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bydureon® (exenatide extended-release pen)</td>
<td>Bydureon BCise® (exenatide extended-release auto-injection)</td>
</tr>
<tr>
<td>Byetta® (exenatide) §</td>
<td>Ozempic® (semaglutide injection)</td>
</tr>
<tr>
<td>Trulicity® (dulaglutide) PD</td>
<td>Rybelsus® (semaglutide tablet)</td>
</tr>
<tr>
<td>Victoza® (liraglutide)</td>
<td>Soliqua® (insulin glargine/lixisenatide)</td>
</tr>
<tr>
<td></td>
<td>Xultophy® (insulin degludec/liraglutide)</td>
</tr>
<tr>
<td></td>
<td>Adlyxin® (lixisenatide)</td>
</tr>
</tbody>
</table>
Coverage Guidelines
Authorization 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. Prescriber documented 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. Prescriber documented adverse reaction, inadequate response (defined as at least 90 days of therapy within a 120-day time period) or contraindication to metformin
      ii. Prescriber documented 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. Prescriber documented 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 (including documentation of needle phobia) 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.

† For requests for Adlyxin® (lixisenatide), Bydureon BCise® (exenatide extended-release auto-injection), Ozempic® (semaglutide injection), or Rybelsus® (semaglutide tablet), prediabetes may be accepted as an appropriate diagnosis if all other criteria are met.

Limitations
1. Initial approval and reauthorizations will be granted for 12 months.
2. The following quantity limits apply:
<table>
<thead>
<tr>
<th>Drug</th>
<th>Quantity/30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bydureon Bcise</td>
<td>4 autoinjectors</td>
</tr>
<tr>
<td>Adlyxin 20mcg/0.2mL</td>
<td>2 pens</td>
</tr>
<tr>
<td>Ozempic 2mg/1.5mL</td>
<td>2 pens</td>
</tr>
<tr>
<td>Ozempic 4mg/3mL</td>
<td>1 pen</td>
</tr>
<tr>
<td>Soliqua</td>
<td>6 prefilled pens</td>
</tr>
<tr>
<td>Rybelsus</td>
<td>30 tablets</td>
</tr>
<tr>
<td>Xultophy</td>
<td>1 carton (5</td>
</tr>
<tr>
<td></td>
<td>prefilled pens)</td>
</tr>
</tbody>
</table>

**Appendix**

**Appendix A: Brand Preferred over Generic**

In addition to any prior authorization requirements that may be listed above, generic medications listed below have Brand name products that are Brand Name Preferred Over Generic

- exenatide

**References**

9. Trulicity (dulaglutide) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; April 2021

**Review History**

09/30/2020 – Updated; Match Masshealth partial unified formulary requirements for implementation on 1/1/21
05/19/2021 – Updated and Reviewed; References updated; Added Ozempic 4mg/3mL formulation to PA and Limitations to match MH UPPL for 7/1/2021. Effective 07/01/2021.
11/17/2021 – Reviewed and Updated for Nov P&T; Adlyxin® (lixisenatide) added to criteria; include new footnotes to GLP-1 agonists requiring PA to allow for approval of requests for members with prediabetes based on published consensus guideline. Additionally, footnote for GLP-1 agonists was updated to clarify that members with needle-phobia can be reviewed using the same guidance as those with a contraindication to injectable formulations. Effective 1/1/2022

**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.