### Incretin Mimetics
**Effective April 17, 2019**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Benefit</th>
<th>Program Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ MassHealth</td>
<td>☒ Pharmacy Benefit</td>
<td>☒ Prior Authorization</td>
</tr>
<tr>
<td>☐ Commercial/Exchange</td>
<td>☐ Medical Benefit (NLX)</td>
<td>☐ Quantity Limit</td>
</tr>
</tbody>
</table>

| Specialty Limitations | N/A |

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
<th>Medical Specialty Medications (NLX)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
<td>Fax: 866-249-6155</td>
<td></td>
</tr>
<tr>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
<td>Fax: 866-255-7569</td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td>Fax: 888-836-0730</td>
<td></td>
</tr>
<tr>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
<td></td>
</tr>
<tr>
<td>All Plans</td>
<td>Phone: 844-345-2803</td>
<td>Fax: 844-851-0882</td>
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#### Overview
Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

#### Initial Step-Therapy Requirements:
**First-Line**: Medications listed on first-line are covered without prior-authorization.  
**Second-Line**: Second-line medications will pay if the member has filled a first-line medication or a second-line medication within the past 180 days.

#### Coverage Guidelines

<table>
<thead>
<tr>
<th>FIRST-LINE</th>
<th>SECOND-LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>metformin or a metformin-containing product</td>
<td>Byetta (exenatide) (MH Preferred Brand)</td>
</tr>
<tr>
<td></td>
<td>Bydureon (exenatide once weekly)</td>
</tr>
<tr>
<td></td>
<td>Ozempic (semaglutide)</td>
</tr>
<tr>
<td></td>
<td>Tanzeum (albiglutide)</td>
</tr>
<tr>
<td></td>
<td>Trulicity (dulaglutide)</td>
</tr>
<tr>
<td></td>
<td>Victoza (liraglutide)</td>
</tr>
</tbody>
</table>

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member meets the following criteria:

1. A diagnosis of Type II Diabetes **AND**
2. The patient has been started and stabilized on the requested medication **OR**

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2. Patient has tried metformin or a metformin-containing product AND had a documented inadequate response

OR

2. Patient has a documented side effect, allergy or contraindication (i.e., renal insufficiency, liver disease, heart failure, history of lactic acidosis) to metformin.

Limitations

1. Approvals will be granted for 36 months.
2. The following quantity limits apply:

<table>
<thead>
<tr>
<th>Product</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bydureon, Byetta, Tanzeum, and Trulicity</td>
<td>4 units per 28 days</td>
</tr>
<tr>
<td>Ozempic</td>
<td>2 pens per 28 days</td>
</tr>
<tr>
<td>Victoza</td>
<td>3 pens per 30 days</td>
</tr>
</tbody>
</table>

References


Review History
09/25/06 – Updated
04/23/07 – Reviewed
04/28/08 – Updated
08/21/08 – Metformin-containing products
02/01/09 – Prandimet
04/27/09 – Reviewed
04/26/10 – Reviewed
11/01/10 – Victoza criteria
12/15/10 – Disclaimer
04/25/11 – Reviewed
03/19/12 – Bydureon
04/23/12 – Updated
04/22/13 – Reviewed
04/27/13 – Updated
04/28/14 – Reviewed
11/03/14 – Bydureon Pen added
01/12/15 – Added Tanzeum
04/25/16 – Updated
04/24/17 – Updated
04/23/18 – Added Ozempic
04/17/19 – Removed Tanzeum

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