GLP-1 RECEPTOR AGONISTS PRIOR AUTHORIZATION FORM

(form effective 1/1/2026)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

BENEFICIARY INFORMATION

Beneficiary name:	Beneficiary ID #:	DOB:

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	NPI:	State license #:
Street address:		
City/state/zip:		
Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation):*	DX code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL REQUESTS

NOTE: GLP-1 Receptor Agonists are not covered for the treatment of overweight or obesity. GLP-1 Receptor Agonists are covered for the treatment of diagnoses that are indicated in the FDA-approved package labeling or other medically accepted indications excluding treatment of overweight or obesity. Saxenda (liraglutide) will no longer be covered for any indication.

FOR THE TREATMENT OF DIABETES:

1. **For a PREFERRED GLP-1 Receptor Agonist for the treatment of diabetes, submit documentation of the beneficiary's diagnosis.**
2. **For a NON-PREFERRED GLP-1 Receptor Agonist for the treatment of diabetes:**
   ☐ Has tried and failed or has a contraindication or an intolerance to the preferred GLP-1 Receptor Agonists

FOR ALL OTHER DIAGNOSES EXCEPT DIABETES:

1. **For the treatment of moderate to severe OBSTRUCTIVE SLEEP APNEA (OSA), all of the following:**
   ☐ Has a recent BMI greater than or equal to 35 kg/m^2
   ☐ Has a diagnosis of moderate to severe OSA confirmed within the last two years
   ☐ Has excessive daytime sleepiness or reduced sleep-related quality of life
   ☐ Is adherent to positive airway pressure (PAP) treatment or is currently using or is intolerant to an oral appliance for OSA
   ☐ Had a recent six-month trial of and plan to continue lifestyle changes and behavioral modifications (e.g., healthy diet and increased physical activity) OR a medical reason why immediate treatment is necessary
2. **For the reduction in risk of MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE), all of the following:**
   ☐ Has a recent BMI greater than or equal to 27 kg/m^2
   ☐ Has established cardiovascular disease (e.g., history of MI, stroke, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease or has intermittent claudication with an ABI <0.85 at rest)
   ☐ Is receiving optimized pharmacotherapy for established cardiovascular disease based on current consensus guidelines
   ☐ The requested GLP-1 Receptor Agonist will be used in combination with lifestyle changes and behavioral modifications
3. **For the treatment of NONCIRRHOTIC METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH), all of the following:**
   ☐ Has a diagnosis of MASH with moderate to advanced liver fibrosis (consistent with stage F2 or F3 fibrosis)
   ☐ Does not have significant alcohol use or alcohol dependence
   ☐ Is receiving optimized pharmacotherapy for established comorbid diseases based on current consensus guidelines
   ☐ If currently taking Rezdiffra (resmetirom) with a plan to add concomitant therapy with a GLP-1 Receptor Agonist, failed to show improvement in liver fibrosis after a trial of Rezdiffra (resmetirom) for greater than or equal to 12 months
   ☐ The requested GLP-1 Receptor Agonist will be used in combination with lifestyle changes and behavioral modifications
4. **For a NON-PREFERRED GLP-1 Receptor Agonist for a diagnosis other than diabetes, indicate which GLP-1 Receptor Agonists have been tried or cannot be tried:**
   ☐ Mounjaro (tirzepatide) ☐ Ozempic (semaglutide) ☐ Wegovy (semaglutide)

RENEWAL REQUESTS

FOR THE TREATMENT OF DIABETES:

1. **For a PREFERRED GLP-1 Receptor Agonist for the treatment of diabetes, submit documentation of beneficiary's diagnosis.**
2. **For a NON-PREFERRED GLP-1 Receptor Agonist for the treatment of diabetes:**
   ☐ Has tried and failed or has a contraindication or an intolerance to the preferred GLP-1 Receptor Agonists

FOR ALL OTHER DIAGNOSES EXCEPT DIABETES:

1. **For the reduction in risk of MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE), both of the following:**
   ☐ Is receiving optimized pharmacotherapy for established cardiovascular disease based on current consensus guidelines
2. **For the treatment of NONCIRRHOTIC METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH), all of the following**
   ☐ Does not have significant alcohol use OR alcohol dependence
   ☐ Is receiving optimized pharmacotherapy for established comorbid diseases based on current consensus guidelines
   ☐ If the beneficiary has been using the GLP-1 Receptor Agonist for greater than or equal to one year, experienced at least one of the following:
      ☐ Resolution of steatohepatitis AND improvement or no worsening of liver fibrosis
      ☐ Improvement of liver fibrosis AND no worsening of steatohepatitis
3. **For the treatment of moderate to severe OBSTRUCTIVE SLEEP APNEA (OSA), all of the following:**
   ☐ One of the following:
      ☐ Has been using the GLP-1 Receptor Agonist for LESS THAN SIX MONTHS and:
         ☐ Has documentation of lifestyle changes and behavioral modifications (e.g., healthy diet and increased physical activity)
      ☐ Has been using the GLP-1 Receptor Agonist for SIX MONTHS OR LONGER and one of the following:
         ☐ If initial dose titration has been completed and the beneficiary has been using the GLP-1 Receptor Agonist for at least three consecutive months at the maximum tolerated dose, has 5% total body weight loss and documentation of dietary changes
         ☐ If initial dose titration has not been completed and/or the beneficiary has been using the GLP-1 Receptor Agonist for less than three consecutive months at the maximum tolerated dose, has documentation of dietary changes
   ☐ One of the following:
      ☐ Is currently using and has documented adherence to positive airway pressure (PAP) unless PAP is no longer recommended
      ☐ Has a medical reason why PAP cannot be used or is still intolerant to PAP despite troubleshooting strategies and is using or is intolerant to an oral appliance for OSA
   ☐ Has been using the GLP-1 Receptor Agonist for ONE YEAR OR LONGER and:
      ☐ Has documentation of improvement in OSA symptoms since starting the requested drug (e.g., decreased AHI, improvement in daytime sleepiness)
4. **For ALL INDICATIONS other than diabetes:**
   ☐ Is continuing lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity)
5. **For a NON-PREFERRED GLP-1 Receptor Agonist for a diagnosis other than diabetes, indicate which GLP-1 Receptor Agonists have been tried or cannot be tried:**
   ☐ Mounjaro (tirzepatide) ☐ Ozempic (semaglutide) ☐ Wegovy (semaglutide)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: