Louisiana Medicaid
Diabetes – Hypoglycemics – Incretin Mimetics / Enhancers

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- ~~p~~Prior authorization for non-preferred incretin mimetic/enhancers (except GLP-1 agonists); **AND**~~.~~
- Clinical authorization for GLP-1 agonists.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation and Continuation of Therapy (Except GLP-1 Agonists)

- ~~The recipient has a diagnosis approved for the medication requested, if applicable (see POS Edits); **AND**~~
- ~~If the request is for a GLP-1, the recipient meets the minimum age requirement (see POS Edits); **AND**~~
- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a DPP-4, the recipient has had a failure to respond or an intolerance to one preferred DPP-4; **OR**
- If the request is for a DPP-4 / metformin combination, the recipient has had a failure to respond or an intolerance to one preferred DPP-4 / metformin combination; **OR**
- If the request is for DPP-4 / metformin extended-release combination, the recipient has had a failure to respond or an intolerance to one preferred DPP-4 / metformin extended release combination; **OR**
- If the request is for a DPP-4 / thiazolidinedione combination, the recipient has had a failure to respond or an intolerance to one preferred alternative in this therapeutic class; **OR**
- ~~If the request is for a GLP-1, the recipient has had a failure to respond or an intolerance to a preferred GLP-1; **OR**~~
- If the request is for a non-preferred amylin analog:
  - The prescriber **states on the request** that the recipient has failed to achieve glycemic control despite optimal insulin therapy; **AND**
  - The recipient has had a failure to respond or an intolerance to one preferred amylin analog (if available); **OR**
- **ONE** of the following is required:
  - The recipient has a *documented contraindication* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
  - The recipient is established on the medication with positive clinical outcomes**.**

Duration of approval for initiation and continuation of therapy: 12 months

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GLP-1 Agonists

Initial Approval Criteria

- The recipient meets the minimum age requirement (see POS Edits); **AND**

- The recipient has a diagnosis of type 2 diabetes mellitus; **AND**
- Documentation is provided confirming **ONE** of the following:
    - The recipient has a hemoglobin A1c (A1C) ≥ 6.5% obtained within the previous 6-month period; **OR**
    - **ALL** of the following:
        - The recipient has a hemoglobin A1c (A1C) < 6.5% obtained within the previous 6-month period; **AND**
        - The recipient has a history of a hemoglobin A1c (A1C) ≥ 6.5%; **AND**
        - The request is for Trulicity®, Victoza®, or Ozempic®, and the recipient has established cardiovascular disease including **ONE** of the following:
            - Prior myocardial infarction; **OR**
            - Prior stroke (ischemic or hemorrhagic stroke); **OR**
            - Peripheral arterial disease; **AND**
- If request is for a non-preferred GLP-1 agent **– ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred GLP-1 product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred GLP-1 product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred GLP-1 products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Subsequent Approval Criteria

Note: Subsequent approval criteria should be used only if the recipient has previously obtained an initial approval using the criteria listed above.

- The prescriber states on the request that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initial or subsequent requests: 12 months

References

American Diabetes Association Professional Practice Committee; Introduction and Methodology: *Standards of Care in Diabetes—2024. Diabetes Care* 1 January 2024; 47 (Supplement_1): S1–S4. https://doi.org/10.2337/dc24-SINT

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Dulaglutide (Trulicity) [package insert]. Indianapolis, IN: Eli Lilly and Company; December 2022. https://uspl.lilly.com/trulicity/trulicity.html#pi

Exenatide (Bydureon Bcise) [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals; May 2023. https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/df5ddbd6-546b-43da-b794-56f711189aba/df5ddbd6-546b-43da-b794-56f711189aba_viewable_rendition__v.pdf

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Liraglutide (Victoza) [package insert]. Plainsboro, NJ: Novo Nordisk Inc; July 2023. https://www.novo-pi.com/victoza.pdf

Semaglutide (Ozempic) [package insert]. Plainsboro, NJ: Novo Nordisk Inc; September 2023. https://www.ozempic.com/prescribing-information.html

Semaglutide (Rybelsus) [package insert]. Plainsboro, NJ: Novo Nordisk Inc; January 2024. https://www.novo-pi.com/rybelsus.pdf

Tirzepatide (Mounjaro) [package insert]. Indianapolis, IN: Eli Lilly and Company; May 2024. https://uspl.lilly.com/mounjaro/mounjaro.html#pi

Revision / Date	**Implementation Date**
Single PDL Implementation	May 2019
Formatting changes; removed POS wording / April 2021	July 2021
Diagnosis requirement policy clarification / August 2023	October 2023
Added age requirement criterion, formatting changes / February 2024	April 2024
Added clinical authorization requirement for GLP-1 agonists, updated references / August 2024	TBD