

FAX FORM AND CLINICAL DOCUMENTATION
GLP-1 RECEPTOR AGONISTS PRIOR AUTHORIZATION FORM (form effective 1/1/2026)

Prior authorization guidelines for **GLP-1 Receptor Agonists** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	DX code (<i>required</i>):	

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:

- For a **PREFERRED** GLP-1 Receptor Agonist for the treatment of diabetes, submit documentation of the beneficiary's diagnosis.
- 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

FAX FORM AND CLINICAL DOCUMENTATION
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/m²
- ☐ 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/m²
- ☐ 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 DIAGNOSES EXCEPT DIABETES:
1. For the reduction in risk of MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE):

- ☐ 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

FAX FORM AND CLINICAL DOCUMENTATION**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 TO 866-240-3712****Prescriber Signature:****Date:**

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