carolina complete health

Pharmacy Prior Approval Request for
GLP-1 Receptor Agonists and Combinations

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____

7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____

11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Requests for GLP-1 Receptor Agonists and Combinations (Initial) :

1. Does the beneficiary have a diagnosis of Type 2 Diabetes? ☐ **Yes** ☐ **No**
2. Has the beneficiary had a trial and failure or insufficient response to metformin containing products? ☐ **Yes** ☐ **No**
3. Has the beneficiary had a contraindication or adverse event to metformin? ☐ **Yes** ☐ **No**

List_____

4. Does the beneficiary have established ASCVD? ☐ **Yes** ☐ **No**
5. Does the beneficiary have Chronic Kidney Disease? ☐ **Yes** ☐ **No**
6. **For non-preferred products (in addition to questions 1-5),** Has the beneficiary tried and failed or experienced an insufficient response to at least two preferred products or have a clinical reason that preferred products cannot be tried? ☐ **Yes** ☐ **No**

List:_____

Continuation Requests for GLP-1 Receptor Agonists and Combinations for both preferred and non preferred products:

1. Has the beneficiary improved while on this medication? ☐ **Yes** ☐ **No (Medical Documentation should be attached to this request)**
2. Are individual clinical goals that were set by the provider being met? ☐ **Yes** ☐ **No**
3. Is the beneficiary continuing to make adequate progress towards treatment goals? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/