Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	June 16, 2025

Glucagon-like Peptide-1 (GLP-1) Receptor Agonists

Preferred agents (Clinical Prior Authorization Required): Ozempic® (semaglutide), Trulicity® (dulaglutide), and Victoza® (liraglutide)
***See separate clinical criteria for Mounjaro**

Non-preferred agents: Exenatide, liraglutide (generic for Victoza), Rybelsus® (semaglutide)

LENGTH OF AUTHORIZATION: Up to one year

REVIEW CRITERIA:

- Patient must be ≥ 18 years of age for Ozempic and Rybelsus or patient must be ≥ 10 years of age for Trulicity and Victoza; **AND**
- Patient must have a diagnosis of type 2 diabetes mellitus; **AND**
- Hemoglobin A1C (HbA1c) ≥ 6.5 % measured within the past 6 months (documentation required); **AND**
- Patient must have trial and failure of metformin within the past 2 years unless contraindicated or the patient is intolerant to treatment (*documentation required*); **AND**
- Patient must have previous trial with insufficient response, adverse reaction, or contraindication to preferred GLP-1 Receptor Agonists if the request is for non-preferred agents (*documentation required*).

CONTINUATION OF THERAPY

- Patient met initial review criteria; **AND**
- Documentation of improved clinical response (e.g., decline in HbA1c); **AND**
- Patient has not experienced any treatment-restricting adverse effects; **AND**
- Dosing is appropriate as per labeling or is supported by compendia.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/