



Antidiabetics — GLP-1 Agonists

Washington | Medicaid

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return by fax to **844-493-9207** as soon as possible. Without this information, we may not approve the request.

Apple Health Preferred Drug List

<https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx>

Date of request:	Reference #:	MAS:	
Patient:	Date of birth:	Wellpoint ID:	
Pharmacy name:	Pharmacy NPI:	Telephone number:	Fax number:
Prescriber:	Prescriber NPI:	Telephone number:	Fax number:
Medication and strength:	Directions for use:	Qty/day's supply:	
1. Is this request for a continuation of existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is there documentation showing hemoglobin A1c (HbA1c) is ≤ 7 or has improved from baseline (prior to beginning on GLP-1 treatment)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Provide the patient's HbA1c for the following: Baseline: _____ Date taken: _____ Current (within last 12 months): _____ Date taken: _____			
3. Will the requested product be used in combination with another GLP-1 agonist or DPP4 inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Does the patient have a history of failure, defined as inability to achieve HbA1c of less than (<) 7%, using any of the following for a minimum of 90 continuous days unless not tolerated, contraindicated, or clinically inappropriate? (check all that apply) <input type="checkbox"/> Metformin at maximum or highest tolerated dose <input type="checkbox"/> Liraglutide at maximum or highest tolerated dose			
5. Indicate the patient's diagnosis and answer the associated questions as indicated: <input type="checkbox"/> Type 2 diabetes (T2DM) or an HbA1c ≥ 6.5 with any of the following: (check all that apply)			

Coverage provided by Wellpoint Washington, Inc.

Wellpoint Washington, Inc. profoundly acknowledges and respects the inherent sovereignty of the federally recognized Tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the Tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the Tribes, a bond reiterated by the Centennial Accord and established by RCW 43.376. We heartily commit to enhancing our coordination, collaboration, and recognition of the deeply rooted traditions and values of the Tribal communities.

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<input type="checkbox"/> Other. Specify:		
<input type="checkbox"/> No		
11. Does patient have any of the following cardiovascular risk factors? Check all that apply:		
<input type="checkbox"/> Chronic kidney disease		
<input type="checkbox"/> Coronary, carotid, or lower extremity artery stenosis exceeding 50%		
<input type="checkbox"/> Dyslipidemia		
<input type="checkbox"/> Hypertension		
<input type="checkbox"/> Left ventricular hypertrophy		
<input type="checkbox"/> Myocardial ischemia		
<input type="checkbox"/> Obesity BMI ≥ 30 kg/m ²		
<input type="checkbox"/> Prediabetes		
For the diagnosis of type 2 diabetes (T2DM) with moderate to severe obstructive sleep apnea (OSA):		
12. Provide patient's BMI _____ kg/m ²		
13. Does the patient have a polysomnogram showing moderate to severe obstructive sleep apnea as defined as an overall AHI, AHI-3%, AHI-4%, or RDI ≥ 15 obstructive respiratory events per hour (apneas, hypopneas, or RERAs), without the use of a positive airway. pressure device (PAP)?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
14. Has the patient been consulted about the use of PAP?		
<input type="checkbox"/> Yes. Indicate the following for patient:		
<input type="checkbox"/> Declined the use of PAP		
<input type="checkbox"/> Unable to tolerate PAP therapy		
<input type="checkbox"/> Actively using PAP and will continue to use PAP		
<input type="checkbox"/> No		
Chart notes and documentation of HbA1c are required with this request.		
Prescriber signature	Prescriber specialty	Date