HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

MOUNJARO and GLP-1s

liraglutide, Mounjaro®, Ozempic®, Rybelsus®, Trulicity®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ liraglutide, ☐ Mounjaro®(tirzapatide), ☐ Ozempic® (semaglutide), ☐ Rybelsus®(semaglutide), ☐ Trulicity®(dulaglutide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis for which the requested medication is approved to treat per the FDA-approved package insert?	☐	☐	**Please provide documentation**
2. Does the requested member have a diagnosis of type 2 diabetes with evidence of at least one of the following: • A1C > or = 6.5% • Fasting plasma glucose (FPG) > or = 126mg/dL • 2 hr plasma glucose (PG) > or = 200 mg/dL during oral glucose tolerance test (OGTT) • Random PG > or = 200 mg/dL?	☐	☐	**Please provide documentation**
3. Has the member tried and failed generic metformin or a generic metformin-containing combination for at least 30 days or does the member have a contraindication to metformin?	☐	☐	**Please provide documentation**
MOUNJARO®			
1. Has the member tried and failed a preferred GLP-1 without desired effect?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
3. Has the therapy been tolerable and effective?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-148
Origination Date: 07/01/2024
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025