



**NC Medicaid and NC Health Choice
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 (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318