United Healthcare Community Plan

**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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593
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