Jeff Landry
GOVERNOR

Michael Harrington, MBA, MA
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: October 11, 2024

TO: All Louisiana Medicaid Prescribing Providers and Pharmacists

FROM: Kimberly Sullivan, Medicaid Executive Director KLS

SUBJECT: Louisiana Medicaid Pharmacy Updated Criteria for GLP-1 Receptor Agonists - November 2024

Effective November 15, 2024, the Louisiana Medicaid Fee for Service (FFS) Pharmacy Program and Managed Care Organizations (MCOs) updated the criteria for all GLP-1 Receptor agonists, preferred and non-preferred. This update applies to pharmacy claims submitted to Gainwell for FFS and to Magellan for MCOs (Aetna, AmeriHealth Caritas, Healthy Blue, Humana Healthy Horizons, Louisiana Healthcare Connections, and UnitedHealthcare).

GLP-1 Receptor Agonists Criteria Update

Pharmacy claims for GLP-1 Receptor agonists require an approved clinical authorization for preferred and non-preferred agents. The clinical authorization criteria update requires a Hemoglobin A1C (HbA1c) test value. The full Clinical Authorization criteria for GLP-1 Receptor agonists will be listed on the Single Preferred Drug List (PDL) on November 15, 2024 at: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

Additional Information:

If you have questions about the content of this memo, you may contact the FFS pharmacy help desk by phone at (800) 437-9101.

FFS pharmacy claims should be submitted to Gainwell Technologies. MCO pharmacy claims should be submitted to Magellan.

If you have questions about pharmacy claims billing, you may contact the appropriate plan at their pharmacy help desk listed in the chart below.

Healthcare Provider	Pharmacy Help Desk	Pharmacy Help Desk Phone Number
Aetna, AmeriHealth Caritas, Healthy Blue, Humana Healthy Horizons, Louisiana Healthcare Connections, UnitedHealthcare	Magellan	(800) 424-1664
Fee for Service	Gainwell Technologies	(800) 648-0790

Please forward this notice to other providers to assist with notification. Your continued cooperation and support of the Louisiana Medicaid Program efforts to coordinate care and improve health are greatly appreciated.

KS/MBW/GJS

Enclosure

c: Healthy Louisiana Plans
Melwyn B. Wendt
Gainwell Technologies
Magellan

Louisiana Medicaid
Diabetes – Hypoglycemics – Incretin Mimetics / Enhancers

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Prior authorization for non-preferred incretin mimetic/enhancers (except GLP-1 agonists); **AND**
- Clinical authorization for GLP-1 agonists.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation and Continuation of Therapy (Except GLP-1 Agonists)

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a DPP-4, the recipient has had a failure to respond or an intolerance to one preferred DPP-4; **OR**
- If the request is for a DPP-4 / metformin combination, the recipient has had a failure to respond or an intolerance to one preferred DPP-4 / metformin combination; **OR**
- If the request is for DPP-4 / metformin extended-release combination, the recipient has had a failure to respond or an intolerance to one preferred DPP-4 / metformin extended release combination; **OR**
- If the request is for a DPP-4 / thiazolidinedione combination, the recipient has had a failure to respond or an intolerance to one preferred alternative in this therapeutic class; **OR**
- If the request is for a non-preferred amylin analog:
    - The prescriber **states on the request** that the recipient has failed to achieve glycemic control despite optimal insulin therapy; **AND**
    - The recipient has had a failure to respond or an intolerance to one preferred amylin analog (if available); **OR**
- **ONE** of the following is required:
    - The recipient has a *documented contraindication* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
    - The recipient is established on the medication with positive clinical outcomes**.**

Duration of approval for initiation and continuation of therapy: 12 months

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<u>GLP-1 Agonists</u>

<u>Initial</u> Approval Criteria

- The recipient meets the minimum age requirement (see POS Edits); **AND**
- The recipient has a diagnosis of type 2 diabetes mellitus; **AND**
- Documentation is provided confirming **ONE** of the following:
    - The recipient has a hemoglobin A1C (A1C) ≥ 6.5% obtained within the previous 6-month period; **OR**
    - **ALL** of the following:

        - The recipient has an A1C < 6.5% obtained within the previous 6-month period; **AND**
        - The recipient has a history of an A1C ≥ 6.5%; **AND**
        - The request is for Trulicity®, Victoza®, or Ozempic®, and the recipient has established cardiovascular disease including **ONE** of the following:
            - Prior myocardial infarction; **OR**
            - Prior stroke (ischemic or hemorrhagic stroke); **OR**
            - Peripheral arterial disease; **AND**
- If request is for a non-preferred GLP-1 agent **– ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred GLP-1 product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred GLP-1 product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred GLP-1 products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Subsequent Approval Criteria
Note: Subsequent approval criteria should be used only if the recipient has previously obtained an initial approval using the criteria listed above.

- The prescriber states on the request that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initial or subsequent requests: 12 months

References

American Diabetes Association Professional Practice Committee; Introduction and Methodology: *Standards of Care in Diabetes—2024*. *Diabetes Care* 1 January 2024; 47 (Supplement_1): S1–S4. https://doi.org/10.2337/dc24-SINT

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Dulaglutide (Trulicity) [package insert]. Indianapolis, IN: Eli Lilly and Company; December 2022. https://uspl.lilly.com/trulicity/trulicity.html#pi

Exenatide (Bydureon Bcise) [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals; May 2023. https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/df5ddbd6-546b-43da-b794-56f711189aba/df5ddbd6-546b-43da-b794-56f711189aba_viewable_rendition__v.pdf

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Liraglutide (Victoza) [package insert]. Plainsboro, NJ: Novo Nordisk Inc; July 2023. https://www.novo-pi.com/victoza.pdf

Semaglutide (Ozempic) [package insert]. Plainsboro, NJ: Novo Nordisk Inc; September 2023. https://www.ozempic.com/prescribing-information.html

Semaglutide (Rybelsus) [package insert]. Plainsboro, NJ: Novo Nordisk Inc; January 2024. https://www.novo-pi.com/rybelsus.pdf

Tirzepatide (Mounjaro) [package insert]. Indianapolis, IN: Eli Lilly and Company; May 2024. https://uspl.lilly.com/mounjaro/mounjaro.html#pi

Revision / Date	**Implementation Date**
Single PDL Implementation	May 2019
Formatting changes; removed POS wording / April 2021	July 2021
Diagnosis requirement policy clarification / August 2023	October 2023
Added age requirement criterion, formatting changes / February 2024	April 2024
Added clinical authorization requirement for GLP-1 agonists, updated references / August 2024	November 2024