**DATE:** September 2, 2025

**TO:** Commonwealth of Kentucky Medicaid Prescriber Network

**FROM:** MedImpact Healthcare Systems

**Subject:** **Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists Prior Authorization Criteria Changes**

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**Status:** Effective October 1, 2025, the Kentucky Department for Medicaid Services (DMS) will implement new renewal criteria for all **Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists.** This criteria is being implemented to ensure appropriate and timely lab monitoring is being completed (e.g. Hemoglobin A1C) for these agents. The full prior authorization criteria are below with new additions underlined.

**PREFERRED WITH PA (PDP) CRITERIA**

| Agent(s) Subject to Criteria | Criteria for Approval |
|---|---|
| Byetta®<br>Ozempic®<br>Trulicity®<br>Victoza® | **Approval Duration**: 6 months<br><br>**INITIAL APPROVAL CRITERIA**<br>• Diagnosis of Type II Diabetes Mellitus (T2DM) confirmed with clinical documentation including:<br>  ○ ICD-10 diagnosis of T2DM (chart notes within the past 12 months); **AND**<br>  ▪ A1c lab value of 6.5 or greater within the past 6 months; **OR**<br>  ▪ ***Historical A1c that correlates to a T2DM diagnosis (i.e. 6.5 or greater), AND A1C within the past 6 months; AND***<br>• No personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2); **AND**<br>• ***Not used in combination with another GLP-1 receptor agonist OR DPP4 UNLESS the member is changing therapy; AND***<br>• The requested dose does not exceed the maximum FDA-approved dose for treating diabetes mellitus.<br><br>**RENEWAL CRITERIA**<br>• ICD-10 diagnosis of T2DM (chart notes within the past 12 months); ***AND***<br>• ***Clinical documentation must be submitted demonstrating an A1c value within the past 6 months; AND***<br>• ***Provider attests that the patient has been evaluated for safety (e.g. lacks treatment limiting adverse events) and demonstrates a positive response to therapy; AND***<br>• No personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2); **AND**<br>• ***Not used in combination with another GLP-1 receptor agonist OR DPP4 UNLESS the member is changing therapy; AND***<br>• The requested dose does not exceed the maximum FDA-approved dose for treating diabetes mellitus. |

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| | *Drugs used for anorexia, weight loss, or weight gain are excluded from coverage |

**NON-PREFERRED (NPD) OR GENERIC MEDICALLY NECESSARY CRITERIA**

| Agent(s) Subject to Criteria | Criteria for Approval |
|---|---|
| Bydureon BCise®<br>exenatide<br>liraglutide<br>Mounjaro®<br>Rybelsus® | **Approval Duration**: 6 months<br><br>**INITIAL APPROVAL CRITERIA**<br>• Diagnosis of Type II Diabetes Mellitus (T2DM) confirmed with clinical documentation including:<br>  ○ ICD-10 diagnosis of T2DM (chart notes within the past 12 months); **AND**<br>  ▪ A1c lab value of 6.5 or greater within the past 6 months; **OR**<br>  ▪ ***Historical A1c that correlates to a T2DM diagnosis (i.e. 6.5 or greater), AND A1C within the past 6 months; AND***<br>• No personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2); **AND**<br>• ***Not used in combination with another GLP-1 receptor agonist OR DPP4 UNLESS the member is changing therapy; AND***<br>• The requested dose does not exceed the maximum FDA-approved dose for treating diabetes mellitus; **AND**<br>• A ≥ 3-month trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 2 preferred agents, unless otherwise specified (chart notes or claim history must confirm).<br><br>**RENEWAL CRITERIA**<br>• ICD-10 diagnosis of T2DM (chart notes in the past 12 months); **AND**<br>• ***Demonstrate ONE of the following:***<br>  ○ ***A1c of less than or equal to 8% within the past 6 months, OR***<br>  ○ ***Demonstration of improved A1c value, OR***<br>  ○ ***Provider must submit clinical justification for continued therapy;AND***<br>• ***Provider attests that the patient has been evaluated for safety (e.g. lacks treatment limiting adverse events) and demonstrates a positive response to therapy; AND***<br>• No personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2); **AND**<br>• ***Not used in combination with another GLP-1 receptor agonist OR DPP4 UNLESS the member is changing therapy; AND***<br>• The requested dose does not exceed the maximum FDA-approved dose for treating diabetes mellitus.<br>*Drugs used for anorexia, weight loss, or weight gain are excluded from coverage |

The current Kentucky Medicaid Preferred Drug List with the updated prior authorization criteria can be found on the Kentucky Medicaid Provider Portal (https://kyportal.medimpact.com/provider-documents/drug-information).

## KY MCO Contact Information

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| Program Questions | KYMCOPBM@MedImpact.com |
| Pharmacy Help Desk | (800) 210-7628 [24 hours per day/ 7 days per week] |
| Prior Authorizations | Phone (844) 336-2676 [8:00AM - 7:00PM EST/ 7 days per week]; Fax (858) 357-2612 |
| Pharmacy Portal | https://kyportal.medimpact.com/ |
| BIN: 023880 / PCN: KYPROD1 / GROUP: KYM01 | |

## KY FFS Contact Information

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| Program Questions | KYMFFS@MedImpact.com |
| Pharmacy Help Desk | (877) 403-6034 [24 hours per day/ 7 days per week] |
| Prior Authorizations | Phone (877) 403-6034 [8:00AM - 7:00PM EST/ 7 days per week]<br>Fax (858) 357-2612 |
| Pharmacy Portal | https://kyportal.medimpact.com/ |
| BIN: 026309 / PCN: KYPROD1 / GROUP: KYF01 | |