Clinical Policy: Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists

Reference Number: AR.QC.PA.53
Effective Date: 1.1.26
Last Review Date:12.25
Line of Business: Commercial

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following agents contain a synthetic glucagon-like peptide-1 (GLP-1) receptor agonist and require prior authorization: dulaglutide (Trulicity®), exenatide ER (Bydureon®, Bydureon BCise®), exenatide IR (Byetta®), liraglutide/insulin degludec (Xultophy®), lixisenatide (Adlyxin®), lixisenatide/insulin glargine (Soliqua®), semaglutide (Ozempic®, Rybelsus®), and tirzepatide* (Mounjaro™).

** Tirzepatide is a combination GLP-1 and glucose-dependent insulinotropic polypeptide (GIP) receptor agonist.*

FDA Approved Indication(s)

GLP-1 receptor agonists are indicated as adjunct to diet and exercise to improve glycemic control with type 2 diabetes mellitus. Bydureon, Bydureon BCise, and Trulicity are indicated in patients 10 years of age and older, while the other GLP-1 receptor agonists are indicated in adults.

Ozempic, Rybelsus, and Trulicity are also indicated to reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and:

- Established cardiovascular disease (*Ozempic*, *Trulicity*);
- Cardiovascular risk factors (*Trulicity only*).
- Who are at risk for these events (*Rybelsus only*)

Limitation(s) of use:

- Bydureon, Bydureon BCise, and Xultophy are not recommended as a first-line therapy for patients inadequately controlled on diet and exercise.
- GLP-1 receptor agonists should not be used for the treatment of type 1 diabetes. Xultophy and Soliqua are not for the treatment of diabetic ketoacidosis.
- Xultophy and Soliqua have not been studied in combination with prandial insulin. In addition, they are not recommended for use in combination with any other product containing a GLP-1 receptor agonist.
- Other than Xultophy, GLP-1 receptor agonists have not been studied in patients with a history of pancreatitis. Other antidiabetic therapies should be considered.
- Trulicity is not for patients with pre-existing severe gastrointestinal disease.
- Adlyxin and Soliqua are not recommended in patients with gastroparesis.
- Bydureon and Bydureon BCise are extended-release formulations of exenatide. Do not coadminister with other exenatide containing products.
- Xultophy contains liraglutide and should not be co-administered with other liraglutide-containing products.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that GLP-1 receptor agonists are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Preferred GLP-1 RA Therapy* (must meet all)**:**
** If request is for a GLP-1 RA other than Trulicity, Ozempic, Rybelsus, Soliqua, or Mounjaro, please refer to criteria set I.B below*

1. Diagnosis of type 2 diabetes mellitus;
2. Request is for Trulicity, Ozempic, Rybelsus, Soliqua, or Mounjaro;
3. Age is one of the following (a or b):
   a. Trulicity,: ≥ 10 years;
   b. Ozempic, Rybelsus, Soliqua, Mounjaro: ≥ 18 years;
4. Requested product is not prescribed concurrently with another GLP-1 receptor agonist;
5. Dose does not exceed the FDA-approved maximum recommended dose (*see Section V*).

Approval duration: 12 months

B. Type 2 Diabetes Mellitus* (must meet all)**:**
** If request is for, Trulicity, Ozempic, Rybelsus, Soliqua, or -Mounjaro, please refer to criteria set I.A above for preferred GLP-1 RA Therapy.*

1. Diagnosis of type 2 diabetes mellitus;
2. Request is for Adlyxin, Bydureon, Bydureon BCise, Byetta, or Xultophy;
3. Age is one of the following (a or b):
   a. Bydureon, Bydureon BCise: ≥ 10 years;
   b. Adlyxin, Byetta, Xultophy: ≥ 18 years;
4. Member meets one of the following (a, b, c, d, or e):
   a. Failure of ≥ 3 consecutive months of metformin as evidenced by HbA1c ≥ 7%, unless contraindicated or clinically significant adverse effects are experienced;
   b. For antidiabetic medication-naïve members, requested agent is approvable if intended for concurrent use with metformin due to HbA1c ≥ 8.5% (drawn within the past 3 months);
   c. Request is for an agent with proven cardiovascular benefit (Ozempic, Trulicity,Rybelsus,), and member has established atherosclerotic cardiovascular disease (ASCVD), indicators of high ASCVD risk (*see Appendix D*), or chronic kidney disease;
   d. Member has metabolic dysfunction-associated steatotic liver disease (MASLD), and (i):
      i. Member is overweight (body mass index [BMI] 25-29.9 kg/m2) or obese (BMI ≥ 30 kg/m2);
   e. Member has metabolic dysfunction-associated steatohepatitis (MASH), and (i):
      i. Failure of ≥ 3 consecutive month trial of pioglitazone, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of all of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
   a. ≥ 3 consecutive months of each of the following (i, and ii):

i. Trulicity;
ii. Ozempic or Rybelsus;

b. Sodium-glucose co-transporter 2 (SGLT2) inhibitor (see *Appendix B*);

6. Requested product is not prescribed concurrently with another GLP-1 receptor agonist;
7. Dose does not exceed the FDA-approved maximum recommended dose (*see Section V*).

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;Requested product is not prescribed concurrently with another GLP-1 receptor agonist;
3. If request is for a dose increase, new dose does not exceed the FDA-approved maximum recommended dose (*see Section V*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PA.154 for health insurance marketplace or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AACE: American Association of Clinical Endocrinologists
ACE: American College of Endocrinology
ADA: American Diabetes Association
ASCVD: atherosclerotic cardiovascular disease
ER: extended-release
FDA: Food and Drug Administration
GIP: glucose-dependent insulinotropic polypeptide
GLP-1: glucagon-like peptide-1
HbA1c: glycated hemoglobin
IR: immediate-release
SGLT2: sodium-glucose co-transporter 2

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
metformin (Fortamet®, Glucophage®, Glucophage® XR, Glumetza®)	Regular-release (Glucophage): 500 mg PO BID or 850 mg PO QD; increase as needed in increments of 500 mg/week or 850 mg every 2 weeks Extended-release: • Fortamet, Glumetza: 1,000 mg PO QD; increase as needed in increments of 500 mg/week • Glucophage XR: 500 mg PO QD; increase as needed in increments of 500 mg/week	Regular-release: 2,550 mg/day Extended-release: 2,000 mg/day
SGLT2 Inhibitors		
Benzavvy (bexagliflozin)	20 mg PO QD	20 mg/day
Farxiga® (dapagliflozin)	5 mg PO QD To reduce the risk of hospitalization for heart failure, the recommended dose is 10 mg PO QD	10 mg/day
Glyxambi® (empagliflozin/ linagliptin)	One 10/5 mg tablet PO QD	25/5 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Invokamet® (canagliflozin/ metformin)	One 50/500 mg tablet PO BID	300/2,000 mg/day
Invokamet® XR (canagliflozin/ metformin)	Two 50/500 mg tablets PO QD	300/2,000 mg/day
Invokana® (canagliflozin)	100 mg PO QD	300 mg/day
Jardiance® (empagliflozin)	10 mg PO QD	25 mg/day
Qtern® (dapagliflozin/saxagliptin)	One 5/5 mg tablet PO QD	10/5 mg/day
Qternmet® XR (dapagliflozin/ saxagliptin/metformin)	Individualized dose PO QD	10/5/2,000 mg/day
Segluromet™ (ertugliflozin/ metformin)	Individualized dose PO BID	15/2,000 mg/day
Steglatro™ (ertugliflozin)	5 mg PO QD	15 mg/day
Steglujan™ (ertugliflozin/sitagliptin)	One 5/100 mg tablet PO QD	15/100 mg/day
Synjardy® (empagliflozin/metformin)	Individualized dose PO BID	25/2,000 mg/day
Synjardy® XR (empagliflozin/ metformin)	Individualized dose PO QD	25/2,000 mg/day
Trijardy™ XR (empagliflozin/ linagliptin/ metformin)	Individualized dose PO QD	25/5/2,000 mg/day
Xigduo® XR (dapagliflozin/ metformin)	Individualized dose PO QD	10/2,000 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Hypersensitivity to any product components
  - Personal or family history of medullary thyroid carcinoma or multiple endocrine neoplasia syndrome type 2 (*all GLP-1 receptor agonists other than Byetta, Adlyxin, and Soliqua*)
  - Use during episodes of hypoglycemia (*Soliqua and Xultophy only*)
  - History of drug-induced immune-mediated thrombocytopenia from exenatide products (*Bydureon, Bydureon BCise, and Byetta only*)
- Boxed warning(s): thyroid C-cell tumors (*all GLP-1 receptor agonists other than Byetta, Adlyxin, and Soliqua*)

Appendix D: General Information

- Per the American Diabetes Association (ADA) and American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) guidelines:
  - Metformin is recommended for all patients with type 2 diabetes. It is effective and safe, is inexpensive, and may reduce risk of cardiovascular events and death. Monotherapy is recommended for most patients; however:

        - Starting with dual therapy (i.e., metformin plus another agent, such as a sulfonylurea, thiazolidinedione, dipeptidyl peptidase-4 inhibitor, SGLT2 inhibitor, GLP-1 receptor agonist, or basal insulin) may be considered for patients with baseline HbA1c ≥ 1.5% above their target. According to the ADA, a reasonable HbA1c target for many non-pregnant adults is < 7% (≤ 6.5% per the AACE/ACE).
        - Starting with combination therapy with insulin may be considered for patients with baseline HbA1c > 10% or if symptoms of hyperglycemia are present.
        - For patients with established ASCVD or indicators of high ASCVD risk, heart failure, or chronic kidney disease, use of an SGLT2 inhibitor or GLP-1 receptor agonist with demonstrated cardiovascular benefit is recommended as part of the glucose-lowering regimen independent of HbA1c and metformin use.
    - If the target HbA1c is not achieved after approximately 3 months of monotherapy, dual therapy should be initiated. If dual therapy is inadequate after 3 months, triple therapy should be initiated. Finally, if triple therapy fails to bring a patient to goal, combination therapy with insulin should be initiated. Each non-insulin agent added to initial therapy can lower HbA1c by 0.7-1%.
- According to the ADA, ASCVD includes coronary heart disease, cerebrovascular disease, or peripheral arterial disease presumed to be of atherosclerotic origin. Per American College of Cardiology, indicators of high ASCVD risk are age ≥ 55 years with coronary, carotid, or lower-extremity artery stenosis > 50%; left ventricular hypertrophy; retinopathy; and other end organ damage.

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Adlyxin (lixisenatide)	Initial dose: 10 mcg SC QD for 14 days Maintenance dose: 20 mcg SC QD	20 mcg/day
Bydureon (exenatide ER)	2 mg SC once weekly	2 mg/week
Bydureon BCise (exenatide ER)	2 mg SC once weekly	2 mg/week
Byetta (exenatide IR)	5 mcg to 10 mcg SC BID	20 mcg/day
Mounjaro (tirzepatide)	Initial dose: 2.5 mg SC once weekly. May increase by 2.5 mg every 4 weeks up to 15 mg once weekly	15 mg/week
Ozempic (semaglutide)	0.25 mg to 2 mg SC once weekly, increased no more frequently than every 4 weeks	2 mg/week
Rybelsus (semaglutide)	Initial dose: 3 mg PO QD. After 30 days on the 3 mg dose, increase to 7 mg PO QD. May increase to 14 mg PO QD if needed after at least 30 days on the 7 mg dose	14 mg/day
Soliqua (lixisenatide/ insulin glargine)	Treatment naïve to basal insulin or GLP-1 receptor agonist, currently on a GLP-1 receptor agonist, or currently on less than 30 units of basal insulin daily: 15 units	60 units insulin/20 mcg lixisenatide/day

Drug Name	Dosing Regimen	Maximum Dose
	(15 units insulin/5 mcg lixisenatide) SC QD Currently on 30 to 60 units of basal insulin daily, with or without GLP-1 receptor agonist: 30 units (30 units insulin/10 mcg lixisenatide) SC QD	
Trulicity (dulaglutide)	0.75 mg to 1.5 mg SC once weekly For adults only: May increase to 3 mg once weekly if needed after at least 4 weeks on 1.5 mg dose. May further increase to 4.5 mg once weekly if needed after at least 4 weeks on 3 mg dose.	Pediatrics: 1.5 mg/week Adults: 4.5 mg/week
Xultophy (liraglutide/ insulin degludec)	Treatment naïve to basal insulin or GLP-1 receptor agonist: 10 units (10 units of insulin/0.36 mg liraglutide) SC QD Treatment experienced to basal insulin or GLP-1 receptor agonist: 16 units (16 units insulin/0.58 mg liraglutide) SC QD	50 units insulin/1.8 mg liraglutide/day

VI. Product Availability

Drug Name	Availability
Adlyxin (lixisenatide)	Multi-dose prefilled pen: 50 mcg/mL in 3 mL (14 doses; 10 mcg/dose), 100 mcg/mL in 3 mL (14 doses; 20 mcg/dose)
Bydureon (exenatide ER)	• Single-dose tray: 2 mg vial • Single-dose prefilled pen: 2 mg pen
Bydureon BCise (exenatide ER)	Single-dose autoinjector: 2 mg
Byetta (exenatide IR)	Prefilled pen: 5 mcg/dose (0.02 mL) in 1.2 mL (60 doses), 10 mcg/dose (0.04 mL) in 2.4 mL (60 doses)
Mounjaro (tirzepatide)	• Single-dose prefilled pen: 2.5 mg/0.5 mL, 5 mg/0.5 mL, 7.5 mg/0.5 mL, 10 mg/0.5 mL, 12.5 mg/0.5 mL, 15 mg/0.5 mL • Single-dose vial: 2.5 mg/0.5 mL, 5 mg/0.5 mL, 7.5 mg/0.5 mL, 10 mg/0.5 mL, 12.5 mg/0.5 mL, 15 mg/0.5 mL
Ozempic (semaglutide)	Prefilled pen: • 2 mg/3 mL (0.68 mg/mL); delivers 0.25 mg or 0.5 mg per injection • 4 mg/3 mL (1.34 mg/mL); delivers 1 mg per injection • 8 mg/3 mL (2.68 mg/mL); delivers 2 mg per injection
Rybelsus (semaglutide)	Tablets: 3 mg, 7 mg, 14 mg

Drug Name	Availability
Soliqua (lixisenatide/ insulin glargine)	Single-patient use pen: 33 mcg/100 units per mL in 3 mL
Trulicity (dulaglutide)	Single-dose prefilled pen: 0.75 mg/0.5 mL, 1.5 mg/0.5 mL, 3 mg/0.5 mL, 4.5 mg/0.5 mL
Xultophy (liraglutide/ insulin degludec)	Single-patient use pen: 3.6 mg/100 units per mL in 3 mL

VII. References

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Initial Policy creation and review	11.1.24	
1Q 2025 annual review: recommended changes from CPS SDC based on availability of new generic products for Victoza, generic liraglutide added to formulary without PA and brand Victoza to be reviewed with HIM.PA.103.	01.08.25	
Updated based on new FDA approval of Rybelsus for MACE risk reduction, inclusion of criteria steps for MASH/MASLD indications	12.12.25	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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