

Date	Player/Plan	Drug/Device	Change
INCRETIN MIMETICS (GLP-1 RAS/GIP) Commercial			
4/25/25	Priority (Optimized)	Trulicity, Mounjaro	Added to PA criteria (iin bold) : T2D diagnosis AND Therapeutic failure after 3 month trial at max dose for at least 2 generic oral anti-diabetic agents AND in conjunction with diet and exercise, and not achieving adequate glycemic control (must be within the last SIX months)
1/2/25	All Plans	liraglutide (generic)	Added liraglutide (generic) - FDA approved as of 12/23/2024.
1/1/25	All Plans	Victoza	Was Preferred Brand, Now: Non-Formulary. FDA approved generic liraglutide on 12/23/24.
Effective 1/1/2025	Express Scripts	GLP-1 RA	Prior authorization criteria updated as of 9/18/24 michmed.org/3xAey: Adlyxin, Byetta, Mounjaro, Ozempic, Rybelsus: If criteria for previous use of an oral medication for diabetes (not including Rybelsus or single-entity metformin) in the past 130 days are not met at the point of service, OR if the patient is < 18 years of age, coverage will be determined by Prior Authorization criteria. Bydureon BCise, Trulicity, Victoza, liraglutide (authorized generic to Victoza): If criteria for previous use of an oral medication for diabetes (not including Rybelsus or single-entity metformin) in the past 130 days are not met at the point of service, OR if the patient is < 10 years of age, coverage will be determined by Prior Authorization criteria. Recommended Authorization Criteria Coverage is recommended in those who meet the following criteria: • FDA-Approved Indication • Type 2 Diabetes Mellitus Approve for 1 year if the patient meets ONE of the following (A or B): If the request is for Adlyxin, Byetta, Mounjaro, Ozempic, Rybelsus: Approve if the patient is ≥ 18 years of age; OR If the request is for Bydureon BCise, Trulicity, Victoza, liraglutide (authorized generic to Victoza): Approve if the patient is ≥ 10 years of age.
1/1/25	HAP Commercial	liraglutide (generic)	Was Non-Preferred, Now Preferred Generic with PA and step therapy
1/1/25	Priority Optimized	Mounjaro, Trulicity	Prior authorization criteria no longer requires A1C between 7% and 9%
INCRETIN MIMETICS Medicare Advantage			
01/01/2025	Aetna MA	liraglutide	Was "Unknown." Now Tier 4 - Non-Preferred.
01/01/2025	BCBSM/BCN MA	GLP-1RA	Bypass PA: ICD-10 (T2D DX) on pharmacy profile from med claim or T2D Rx claim within the past year

Date	Player/Plan	Drug/Device	Change
01/01/2025	HAP MA	liraglutide	Was "Unknown." Now Generic - Tier 2
01/01/2025	HAP MA	Ozempic, Rybelsus	Was "Preferred Brand." Now Not Covered
01/01/2025	Humana MA	Victoza	Was "Preferred Brand" now "Not Covered"
01/01/2025	Priority MA	Victoza	Was "Non-Preferred: PA Trial of Trulicity." Now "Not Covered"
INCRETIN MIMETICS - Medicaid			
01/01/2025	Molina Medicaid	All	Added: Molina Medicaid: PA criteria michmed.org/JDqXY • T2D DX • Documented 3 month trial & failure with metformin • Documented of individualized goals for therapy AND • Provider attestation: No FDA contraindications for use
SGLT2i			
01/01/2025	Michigan Medicaid	Brenzavvy	Was "Unknown." Now Non-Preferred with PA
01/01/2025	Michigan Medicaid	Invokana	Was "Preferred Brand." Now Non-Preferred
Anti-Obesity Medications			
1/1/25	BCBSM Comercial	Wegovy, Saxenda	No longer covered. Provider Bulletin https://providerinfo.bcbsm.com/documents/alerts/2024/202406/alert-20240606-changes-weight-loss-drugs-commercial.pdf
1/1/25	Michigan Medicaid	All	Change disclaimers from Magellan (PBM) to Prime Therapeutics (PBM) with updated links to PA criteria

Date	Player/Plan	Drug/Device	Change
CGM			
4/25/25	All Plans	CGM	Abbott is discontinuing its Libre 2 and Libre 3 models, available until 09/30/2025. Prescribers can transition to the Libre 2 Plus or Libre 3 Plus models to avoid gaps in care. More info: https://www.freestyle.abbott/us-en/transition.html
4/25/25	United (Commercial)	CGM	FIXED error in criteria, adding hypoglycemic event option: "THREE (3) times daily insulin OR Level 2 or Level 3 hypoglycemic events" UHC Policy updated 7/2024. ADDED Pharmacy option for CGM, in addition to DME. Either can be used, no preferred copay.
01/01/2025	United	CGM	Adapt Health DME supplier phone number change



COVERAGE GUIDE GLP-1 RA / GIP for COMMERCIAL

Find a glossary of ICD10 codes on last page.

COMMERCIAL PLAN Formulary Link	MOUNJARO <i>Tirzepatide</i> Injectable - Weekly	TRULICITY <i>Dulaglutide</i> Injectable - Weekly	OZEMPIC <i>Semaglutide (SQ)</i> Injectable - Weekly	RYBELSUS <i>Semaglutide</i> Oral - Daily	VICTOZA <i>Liraglutide</i> Injectable - Daily	LIRAGLUTIDE <i>(generic)</i> Injectable - Daily
AETNA michmed.org/97Ay9	Preferred Bypass PA: ICD10 in RX or metformin claim	Preferred Bypass PA: ICD10 in RX or metformin claim	Preferred Bypass PA: ICD10 in RX or metformin claim	Preferred Bypass PA: ICD10 in RX or metformin claim	Non Formulary	Generic PA
BCBSM/BCN michmed.org/nmxVD	Preferred¹ Bypass PA (see note on right)	Preferred¹ Bypass PA (see note on right)	Preferred¹ Bypass PA (see note on right)	Preferred¹ Bypass PA (see note on right)	Non Preferred/ Not Covered²	Generic¹ Bypass PA (see note on right)
EXPRESS SCRIPTS michmed.org/Dyq2x	Preferred Bypass PA: T2D DX	Preferred Bypass PA: T2D DX	Preferred Bypass PA: T2D DX	Preferred Bypass PA: T2D DX	Not Covered	Unknown
HAP michmed.org/qdV9P	Preferred Brand ST: 90-day trial/failure metformin within last 120 days	Preferred Brand ST: 90-day trial/failure metformin within last 120 days	Preferred Brand ST: 90-day trial/failure etformin within last 120 days	Preferred Brand ST: 90-day trial/failure metformin within last 120 days	Non Formulary	Generic PA ST
PRIORITY³ michmed.org/yq299	Preferred Bypass PA: ICD10 on file	Preferred Bypass PA: ICD10 on file	Non Formulary Tier 9	Non Formulary Tier 9	Non Formulary Tier 9	Not Covered
PRIORITY OPTIMIZED michmed.org/BA4Kb	Preferred PA⁴	Preferred PA⁴	Not Covered Tier 9	Not Covered Tier 9	Not Covered Tier 9	Not Covered
UNITED michmed.org/7NJrY	Preferred PA ICD10 in RX or labs if DX < 2 years	Preferred PA ICD10 in RX or labs if DX < 2 years	Preferred PA ICD10 in RX or labs if DX < 2 years	Preferred PA ICD10 in RX or labs if DX < 2 years	Not Covered	Preferred PA ICD10 in RX or labs if DX < 2 years

[1] BCBSM:

Bypass PA: ICD-10 (T2D DX) on pharmacy profile from med claim or T2D Rx claim within the past year

[2] BCBSM: Brand Victoza is Non-Preferred for patients with the Custom and Clinical Formulary and Not Covered for patients with the Custom Select, Preferred Drug list, or closed formulary design.

[3] **For Priority Health employer group and individual HSA plans with chronic condition rider:** Trulicity/Mounjaro have been removed from 2025 Chronic Condition Drug rider list. Affected patients will be paying towards their deductible with these claims now. For example: A patient with a \$4000 deductible, Tier 2 copay of \$40/month, and out of pocket maximum (OOP) of \$8000. In 2024, the patient paid \$40/month on Trulicity until their OOP limit was met. In 2025, the patient would pay ~\$1000/month on Trulicity until their \$4000 deductible is met, then will pay \$40/month until their \$8000 OOP is met.

[4] **Priority Optimized PA for Mounjaro/Trulicity:**

- T2D diagnosis **AND** Therapeutic failure after 3 month trial at max dose for at least 2 generic oral anti-diabetic agents **AND** in conjunction with diet and exercise, and not achieving adequate glycemic control (must be within the last SIX months)
- Documentation should include specific actions, e.g. Patient uses app to track calories and is no longer snacking at night. Patient is walking 30 minutes 3x week. Documentation should be consistent - no discrepancies in past 1-2 months of notes.

MEDICARE PLAN Formulary Link	MOUNJARO <i>Tirzepatide</i> Injectable - Weekly	TRULICITY <i>Dulaglutide</i> Injectable - Weekly	OZEMPIC <i>Semaglutide</i> Injectable - Weekly	RYBELSUS <i>Semaglutide</i> Oral - Daily	VICTOZA <i>Liraglutide</i> Injectable - Daily	LIRAGLUTIDE (generic) Injectable - Daily
AETNA MA michmed.org/8NOrk	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Non-Preferred	Non-Preferred
BCBSM/BCN MA michmed.org/DymRY	Preferred Brand Bypass PA: ICD10 in med claim for pt visit	Preferred Brand Bypass PA: ICD10 in med claim for pt visit	Preferred Brand Bypass PA: ICD10 in med claim for pt visit	Preferred Brand Bypass PA: ICD10 in med claim for pt visit	Non Formulary	Non Formulary ¹
HAP MA michmed.org/8NOrk	Preferred Brand ST: Metformin within last 120 days	Preferred Brand ST: 90-day trial/ failure metformin within last 120 days	Not Covered	Not Covered	Not Covered	Generic Tier 2
HUMANA MA michmed.org/kQ894	Preferred Brand	Preferred Brand	Preferred Brand	Preferred Brand	Not Covered	Non-Preferred Tier 4
PRIORITY MA michmed.org/7NVGN	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Not Covered	Unknown
UNITED MA AARP Preferred michmed.org/YKDR3	Preferred Brand PA	Preferred Brand PA	Preferred Brand PA	Preferred Brand PA	Not Covered	Unknown
WELLCARE MA¹ michmed.org/gRWDV	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Preferred Brand ICD10 in RX PA	Non-Preferred	Non-Formulary

[1] BCBSM/BCN MA:
Generic liraglutide is Tier 1 (Generic) for UAW Trust Group.

[1] Note on Wellcare MA: "Tier 6: Select Care Drugs" denotes certain brand-name medications that treat type 2 diabetes with relatively low copays

Find a glossary of ICD10 codes on Page .



COVERAGE GUIDE

GLP-1 RA / GIP AND SGLT2i for MEDICAID

MEDICAID PLAN Formulary Link	MOUNJARO <i>Tirzepatide</i> Injectable - Weekly	TRULICITY <i>Dulaglutide</i> Injectable - Weekly	OZEMPIC <i>Semaglutide (SQ)</i> Injectable - Weekly	RYBELSUS <i>Semaglutide</i> Oral - Daily	VICTOZA <i>Liraglutide</i> Injectable - Daily	LIRAGLUTIDE (generic) Injectable - Daily
MICHIGAN MEDICAID michmed.org/N2wn8	Non-Preferred PA ³	Preferred Brand PA ^{1, 2} ICD10 in RX or T2D med	Preferred Brand PA ^{1, 2} ICD10 in RX or T2D med	Non-Preferred PA ³	Preferred Brand PA ^{1, 2} ICD10 in RX or T2D med	Non-Preferred PA ³

Find a glossary of ICD10 codes on last page

MEDICAID PLAN Formulary Link	JARDIANCE <i>Empagliflozin</i> Oral - Daily	FARXIGA <i>Dapagliflozin</i> Oral - Daily	INVOKANA <i>Canagliflozin</i> Oral - Daily	STEGLATRO <i>Ertugliflozin</i> Oral - Daily	BRENZAVVY <i>Bexagliflozin</i> Oral - Daily
MICHIGAN MEDICAID michmed.org/N2wn8	Preferred Brand	Preferred Brand	Non-Preferred PA ⁴	Non-Preferred PA ⁴	Not Covered PA ⁴

[1] **Michigan Medicaid:** For most up-to-date PA criteria, see: michmed.org/2VP94 and click on "Drug PA criteria" link.

[2] **Molina Medicaid:** PA criteria michmed.org/JDqXY

- T2D DX
- Documented 3 month trial & failure with metformin
- Documented of individualized goals for therapy AND
- Provider attestation: No FDA contraindications for use

[3] As of Feb 1, 2025, **Non-Preferred GLP-1 RAs** (Bydureon Bcise, exenatide, liraglutide, Mounjaro, Rybelsus) must meet the following PA criteria. Duration of approval: Up to 1 year.

1. Diagnosis of type 2 diabetes
2. Discontinuation of other GLP-1 agonists
3. And one of the following:
 - a. Allergy to the preferred medications; OR
 - b. Contraindication or drug to drug interaction with the preferred medications; OR
 - c. History of unacceptable side effects; OR
 - d. Trial and failure with one preferred medication within same subgroup.

As of Feb 1, 2025, **Non-Preferred SGLT2i's** (dapagliflozin, Inpefa, Steglatro) must meet the following PA criteria. Duration of approval: Up to 1 year.

1. Allergy to the preferred medications; OR
2. Contraindication or drug to drug interaction with the preferred medications; OR
3. History of unacceptable side effects; OR
4. Trial and failure with one preferred medication within same class .

COVERAGE GUIDE

SGLT2i for COMMERCIAL

COMMERCIAL PLAN Formulary Link	JARDIANCE Empagliflozin Oral - Daily	FARXIGA Dapagliflozin ¹ Oral - Daily	INVOKANA Canagliflozin Oral - Daily	STEGLATRO Ertugliflozin Oral - Daily	BRENZAVVY Bexagliflozin Oral - Daily
AETNA michmed.org/97Ay9	Preferred Brand	Preferred Brand	Not Covered	Not Covered	Unknown
BCBSM michmed.org/nmxVD	Preferred Brand	Preferred Brand	Not Covered	Not Covered	Not Covered
EXPRESS SCRIPTS michmed.org/Dyq2x	Preferred	Preferred	Not Covered	Preferred	Unknown
HAP michmed.org/qdV9P	Preferred Brand	Preferred Brand	Non Formulary	Non Formulary	Unknown
PRIORITY michmed.org/yq299	Preferred Brand	Preferred Brand	Non-Preferred ST*	Non-Preferred ST*	Not Covered
PRIORITY OPTIMIZED michmed.org/BA4Kb	Preferred Brand	Preferred Brand	Non-Preferred ST*	Non-Preferred ST*	Not Covered
UNITED michmed.org/7NJrY	Preferred Brand	Non Formulary ST/PA**	Non Formulary ST/PA**	Non Formulary ST/PA**	Non Formulary ST/PA**

¹Authorized generic formulation of dapagliflozin (Farxiga) Not Covered

***Step therapy for Priority**
Must first try Jardiance, Farxiga, Xigduo, or Synjardy

****Step therapy/PA for United**
History of suboptimal response (after three month trial), contraindication or intolerance to metformin AND Jardiance



COVERAGE GUIDE

SGLT2i for MEDICARE ADVANTAGE

MEDICARE PLAN Formulary Link	JARDIANCE <i>Empagliflozin</i> Oral - Daily	FARXIGA <i>Dapagliflozin</i> ¹ Oral - Daily	INVOKANA <i>Canagliflozin</i> Oral - Daily	STEGLATRO <i>Ertugliflozin</i> Oral - Daily	BRENZAVVY <i>Bexagliflozin</i> Oral - Daily
AETNA MA michmed.org/8N Qrk	Preferred Brand	Preferred Brand	Not Covered	Not Covered	Not Covered
BCBSM/BCN MA michmed.org/DymRY	Preferred Brand	Preferred Brand ²	Not Covered ³	Not Covered	Non Formulary
HAP MA michmed.org/8N Qrk	Preferred Brand	Preferred Brand	Non Formulary	Non Formulary	Not Covered
HUMANA MA michmed.org/kQ894	Preferred Brand	Non-Preferred Tier 4	Preferred Brand	Not Covered	Not Covered
PRIORITY MA michmed.org/7N VGN	Preferred Brand	Preferred Brand	Non-Preferred ST*	Not Covered	Not Covered
UNITED AARP michmed.org/YkDR3	Preferred Brand	Preferred Brand	Not Covered	Not Covered	Not Covered
WELLCARE MA** michmed.org/gRWDV	Select Care Tier 6	Select Care Tier 6	Non-Preferred Tier 4	Not Covered	Not Covered

[1] Authorized generic formulation of dapagliflozin (Farxiga) Not Covered

[2] BCBSM/BCN MA:

Farxiga is Non Formulary for UAW Trust Group.

[3] BCBSM/BCN MA:

Invokana is Preferred (Tier 2) for UAW Trust Group.

***Step therapy for Priority**
Must first try Jardiance, Farxiga, Xigduo, or Synjardy

****Note on Wellcare MA:** "Tier 6: Select Care Drugs" denotes certain brand-name medications that treat type 2 diabetes with relatively low copays

PLAN NAME Formulary Link	SAXENDA <i>Liraglutide Injectable - Daily</i>	WEGOVY <i>Semaglutide Injectable - Weekly</i>	ZEPBOUND <i>Tirzepatide Injectable - Weekly</i>	CONTRAVE <i>Naltrexone HCl - Bupropion HC Oral - 2x Daily</i>	LOMAIRA <i>Phentermine 8mg Low Dose Oral - Daily w/Meals</i>	PHENTERMINE <i>Generic - High Dose Oral - Daily w/ Meals</i>	QSYMIA <i>Phentermine - Topiramate Oral - Daily</i>
AETNA michmed.org/97Ay9	Preferred Brand PA¹	Preferred Brand PA¹	Non Formulary	Non Formulary	Not Covered	Preferred Generic PA	Preferred Generic PA
BCBSM* michmed.org/nmxVD	Not Covered ²	Not Covered ²	Not Covered ²	Non-Preferred Brand PA³	Non-Preferred Brand	Preferred Generic	Non-Preferred Brand PA³
EXPRESS SCRIPTS michmed.org/Dyq2x	Not Covered	Preferred PA	Preferred	Non-Preferred PA	Not Covered	Not Covered	Not Covered
HAP michmed.org/qdV9P	Non Formulary	Non Formulary	Non Formulary	Non Formulary	Non Formulary	Non Preferred Generic Tier 1A	Non-Preferred Brand PA
PRIORITY michmed.org/yq299	Not Covered ²	Not Covered ²	Not Covered ²	Non-Preferred ST: Try generic first	Non-Preferred ST: Try generic first	Preferred Generic	Non-Preferred ST: Try generic first
PRIORITY OPTIMIZED michmed.org/BA4Kb	Not Covered ²	Not Covered ²	Not Covered ²	Non-Preferred ST: Try generic first	Not Covered	Preferred Generic	Non-Preferred ST: Try generic first
UNITED michmed.org/7NJrY	Not Covered ³	Not Covered ³	Not Covered ³	Non-Preferred PA³	Non-Preferred PA³	Preferred Generic Tier 1 PA³	Non-Preferred PA³

1. Aetna PA criteria for Wegovy: [michmed.org/QRQMm](#)

2. BCBSM: Saxenda, Wegovy, and Zepbound are Not Covered for fully insured. Coverage for Self-Funded groups may vary.

3. BCBSM PA criteria for Weight Loss Medications (see next page) or BCBSM document [michmed.org/zRQZ](#)

4. Prior authorization may be available for some employers. Patient should contact their HR Benefits Advisor to find out if their employer has an exception allowing these meds. PA criteria for AOM: [michmed.org/GqeVY](#)

Medicare Advantage plans do not cover anti-obesity medications at this time.

ANTI-OBESITY MEDS for Medicaid

PLAN NAME Formulary Link	SAXENDA <i>Liraglutide Injectable - Daily</i>	WEGOVY <i>Semaglutide Injectable - Weekly</i>	ZEPBOUND <i>Tirzepatide Injectable - Weekly</i>	CONTRAVE <i>Naltrexone HCl - Bupropion HC Oral - 2x Daily</i>	LOMAIRA <i>Phentermine 8 Low Dose Oral - Daily w/Meals</i>	PHENTERMINE <i>Generic - High Dose Oral - Daily w/ Meals</i>	QSYMIA <i>Phentermine - Topiramate Oral - Daily</i>
MICHIGAN MEDICAID michmed.org/ N2wn8	Preferred PA	Preferred PA	Preferred PA	Not Covered	Preferred PA	Preferred PA	Not Covered

Michigan Medicaid PDL Prime Therapeutics RX Prior Auth Criteria for Anti-Obesity Medications:

For most up-to-date criteria, see Michigan Medicaid page michmed.org/2VP94 and click on “Drug PA criteria” link (Last checked 2/1/2025)

INITIAL RX (6 MONTHS)

WEGOVY, SAXENDA

- 12 years or older
- Patient age ≥12 years to <18 years must have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity); **OR**
- Patient age ≥12 years to <18 years with BMI in the 85th – 94th percentile (overweight) per CDC growth charts and has at least one of the following weight-related coexisting conditions:
 - Diabetes, sleep apnea, hypertension, or dyslipidemia; **AND**

PHENTERMINE

- 17 years or older

ZEPBOUND

- 18 years or older
- Initial BMI ≥ than 30 kg/m² ; **OR**
- Initial BMI ≥ than 27 kg/m² but <30 kg/m² and at least one of the following:
 - Hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea; **OR**
 - This medication is being prescribed for cardiovascular risk reduction in members with prior myocardial infarction, prior stroke, or peripheral arterial disease; **AND**

1. Prescriber attests that the patient will not use more than one weight loss medication in this drug class concurrently **AND** Prescriber attests that the patient will not use an anti-obesity GLP-1 agonist (Wegovy, Saxenda or Zepbound) concurrently with a DPP4 inhibitor; **AND**
2. For patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatments; **AND**
3. Prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.); **AND**
4. Prescriber attests to patient's absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II; **AND**
5. Prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability; **AND**
6. Prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted.

MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.

Prior Authorization Details

PLAN: AETNA COMMERCIAL

MEDICATION: Wegovy

POLICY: #4774-A 08-2022:

michmed.org/QRQMm

1. 18 years or older AND

- a. The patient has completed at least 3 months of therapy with the requested drug at a stable maintenance dose, AND
- b. The patient lost at least 5 percent of baseline body weight OR the patient has continued to maintain their initial 5% weight loss. Documentation is required for approval.

OR

- c. The requested drug will be used with a reduced calorie diet and increased physical activity for chronic weight management in an adult, AND
- d. The patient has participated in a comprehensive weight management program that encourages behavioral modification, reduced calorie diet and increased physical activity with continuing follow-up for at least 6 months prior to using drug therapy AND BMI of 30+ OR BMI of 27+ with at least one weight related comorbid condition (e.g. hypertension, type 2 diabetes, dyslipidemia).

PLAN: MICHIGAN BCBSM/BCN COMMERCIAL

IMPACTED PATIENTS: BCBSM/BCN Insured Large Group Commercial Members

MEDICATIONS: All GLP-1 RA's for weight loss - Saxenda, Wegovy, Zepbound

Coverage for GLP-1 weight loss drugs for fully insured large group commercial members ended Jan. 1, 2025. Commercial members with self-funded group benefits may have coverage for GLP-1 weight loss drugs if their employer elected to cover these medications.

Commercial self-funded members with coverage for weight loss GLP-1 must fulfill either the 'Standard' coverage criteria or the 'Teladoc Comprehensive Weight Management' coverage criteria to qualify, depending on which criteria their employer has elected to apply. Please use the link below to view these coverage policies.

POLICY: michmed.org/zRQZB

See also: June 6, 2024 provider alert: michmed.org/Z7eqq

Providers can use OptumRx's real-time prescription benefit check (RTPBC) tool, called PreCheck MyScript, to determine if a particular drug is covered under their patient's pharmacy benefit, and to estimate their patient's out-of-pocket costs for specific drugs. This tool is available at no cost and is accessible online through ereferrals.bcbsm.com/bcbsm/bcbsm-drugs-pharm-benefit.shtml, or may be integrated with the provider's EHR system*

Providers should use electronic prior authorization (ePA) tools such as CoverMyMeds or SureScripts to determine which coverage criteria apply based on their patient's pharmacy benefit. These ePA tools provide coverage insights specific to the patient's benefit design and are available at no cost and are accessible online through the Availity Provider Portal, or may be integrated with the provider's EHR system*

*Integration capabilities for real-time prescription benefit check (RTPBC) and ePA platforms may vary by different EHR systems.

MEDICATION: Contrave, Qsymia

1. Age $\geq$ 18 years old
2. BMI $\geq$ 30, or $\geq$ 27 with one weight related condition
3. Current weight (within 30 days) must be submitted to the plan for review
4. Active participation for a minimum of 6 months in a covered BCBSM/BCN lifestyle modification program OR active participation for a minimum of 6 months in an alternative concurrent lifestyle modification program (e.g. recent food diaries, exercise logs, program receipts, app participation, etc.) if member does not have access to a covered BCBSM/BCN program
5. Not to be used in combination with other weight loss products



PLAN	BENEFIT TYPE	TYPE 2 DIABETES DIAGNOSIS AND		ADDITIONAL DOCUMENTATION	ORDERING
		INSULIN	OR NON-INSULIN CRITERIA		
MEDICARE Part B michmed.org/dJ8z3	Order through DME	Insulin treated	"Problematic hypoglycemia" defined as <i>EITHER:</i> Level 2 at least TWO that persist <i>despite at least two</i> prior med adjustments and/or modifications to treatment plan (e.g. raising A1c targets) OR Level 3 history of ONE event ----- <i>Level 2</i> defined as glucose less than 54 mg/dL <i>Level 3</i> defined as less than 54 mg/dL <i>with</i> altered mental and/or physical state requiring third party assistance to treat	Visit for T2D Mgmt: Within 6 months (virtual or in-person) CGM training: Pt or caregiver has received appropriate training. FDA indication for use: For diabetes treatment decisions	DME Preferred Models Abbott Freestyle Libre 2, 2 Plus, 3*, or 3 Plus, Dexcom, and Medtronic <i>*If pt does not have a Libre 2 reader and does not need a standalone reader</i> Note: Abbott Freestyle Libre 2 & 3 will be discontinued 09/30/2025. prescription for 2 Plus or 3 Plus will be needed to avoid gaps in care.
Blue Care Network (BCN) MA	Order through Pharmacy Billed Under Medical	Same as Medicare Part B	Same as Medicare Part B	PRIOR AUTH: Use CoverMyMeds. See BCBSM Disclaimer on last page of CGM guide. Same as Medicare Part B. Patients with non-UAW Trust Group Medicare who are experiencing difficulty obtaining CGM from retail pharmacy under Part B coverage: 800-437-3803 or email Part B mailbox: masrx@bcbsm.com	
HAP MA	Order through Pharmacy	Insulin Verified with claims lookback within 180 days	3+ non-insulin oral medications AND Uncontrolled A1c	PRIOR AUTH: Needed if no insulin, use CoverMyMeds.	Preferred Models Dexcom G6 or G7, Freestyle Libre 2, 2 Plus, 3, or 3 Plus \$0 copay, see preferred vendor Preferred Vendor Pharmacy Advantage

COVERAGE GUIDE

CGMs for Medicaid Plans



Check out Coverage Checker
Now available online:
mct2d.org/coverage-checker

PLAN	BENEFIT TYPE	TYPE 2 DIABETES DIAGNOSIS <u>AND</u>		ADDITIONAL DOCUMENTATION	ORDERING
		INSULIN	OR NON-INSULIN CRITERIA		
MICHIGAN MEDICAID michmed.org/Dyeme	Order through DME	Insulin treated	AND T2D cared for by: PCP, NP, PA, or Endocrinology CGM Education: Patient (or caregiver) has been educated on the use of the CGM and is willing and able to a CGM	PRIOR AUTH: CoverMyMeds or MDHHS michmed.org/BnJxD. Documentation within last 90 days, MUST ALSO HAVE: 1. Frequency of insulin administered per day or IF using insulin pump 2. Current treatment plan. Refill Limitations Year 1 <i>1st order:</i> Written for 6 months. <i>2nd order:</i> Written for 6 months. Year 2 <i>Orders:</i> Written for 12 months.	Preferred Models Abbott Freestyle Libre 2, 2 Plus, 3*, or 3 Plus; Dexcom G6 or G7 Note This policy applies to Medicaid Fee-for-Service (FFS). MHPs and ICOs must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in a MHP or ICO, the provider must check with the beneficiary's MHP/ICO for prior authorization requirements
Molina Medicaid michmed.org/gRWVY	Order through Pharmacy OR DME				
Blue Cross Complete (Medicaid) michmed.org/PJGPA	Order through Pharmacy OR DME	Insulin treated	OR Treatment with non-insulin antihyperglycemic drug ONE of the following (1-8) MUST be documented if NOT on insulin 1. Hypoglycemia (frequent, unaware, OR nocturnal) 2. Weight gain: >5 lb in last 12 months 3. A1C ≥ 7%	PRIOR AUTH: CoverMyMeds or michmed.org/nDqkD. 4. Need for medication changes 5. Initiation of lower carb diet 6. Unable/reluctant to test finger BG 7. On two or more T2D meds 8. Care Team: Working with pt to improve diet/exercise	Preferred Models: Abbott Freestyle Libre 2, 2 Plus, 3, or 3 Plus; Dexcom G6 or G7 Search pharmacy network bccmi.darwinrx.com/PharmacyLocator For reauthorization after 12-months: Treatment of T2D without insulin, must document positive clinical response (i.e. improved A1C, reduced hypoglycemia)

COVERAGE GUIDE

CGMs for Commercial Plans



Check out Coverage Checker
Now available online:
mct2d.org/coverage-checker

PLAN	BENEFIT TYPE	TYPE 2 DIABETES DIAGNOSIS AND		ADDITIONAL DOCUMENTATION	ORDERING
		INSULIN	OR NON-INSULIN CRITERIA		
AETNA Formulary michmed.org/97Ay9	Order through Pharmacy OR DME	Not required	Only "Clinician's recognition of BENEFIT to patient." No T2D Dx required.		Preferred Devices Dexcom G6/G7 (Pharmacy or Medical), Freestyle Libre (through Medical benefit only)
IF PRESCRIBER IS A CURRENT MCT2D AND PDCM PHYSICIAN MEMBER: (AS OF JUNE 1, 2024)					
BCBSM Consult individual plan MCT2D-specific CGM policy as of 6/1/24: michmed.org/AnjzA	Order through Pharmacy OR DME <i>To verify pharmacy or DME: Patient should call the number on the back of insurance card or log in to member.bcbsm.com</i>	If pharmacy benefit and prescriber is an MCT2D or PDCM physician: Insulin is Not required Non-MCT2D or PDCM participating prescribers: See next page for BCBSM coverage criteria.	None	Prescribing physician must attest to being a current physician member of MCT2D or PDCM. Include in prescription order. For Pharm RX: No PA required for MCT2D physicians. For DME: PA auto-approved for MCT2D physicians if the PA is reviewed by Northwood, Inc. ²	Pharmacy Preferred Models Abbott Freestyle Libre 2, 2 Plus, 3, or 3 Plus; Dexcom G6, G7 ¹ Note: Abbott Freestyle Libre 2 & 3 will be discontinued 09/30/2025. prescription for 2 Plus or 3 Plus will be needed to avoid gaps in care. For list of network DME vendors, please visit bcbsm.com/individuals/find-care/ . Use the "Find a Doctor" tool to search for network DME suppliers. ²

*Criteria for pregnant patients: "Pregnant individuals that are not on insulin therapy AND who experience postprandial hyperglycemia as defined by ACOG."

BCBSM Disclaimers and Tips

Please see 02/2025 BCBSM FAQ for CGM Prescribing Providers document: ereferrals.bcbsm.com/docs/common/common-cgm-products-faq-for-prescribing-providers.pdf.

*Criteria for pregnant patients: "Pregnant individuals that are not on insulin therapy AND who experience postprandial hyperglycemia as defined by ACOG."

Preferred CGM Devices

[1] At \$0 Copay Tier: Dexcom G6 receiver, Dexcom G6 transmitter, Dexcom G7 receiver. Northwood, Inc. does not manage or distribute the Eversense CGM implantable sensor. Requests for authorization for Eversense are reviewed by BCBSM/BCN and should be submitted via e-referral after verification of member eligibility and benefits.

Prior Authorization: Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members. Review patient eligibility through the Eligibility & Benefits Inquiry application within the BCBSM provider portal: www.availity.com. **Step 1:** Access application on the Patient Registration menu at the top of the Availity home screen. **Step 2:** Use this application to confirm whether the BCBSM/BCN commercial member has Diabetes Supplies covered under their medical (DME) benefit, and to verify whether the member has pharmacy benefit coverage. Procedure codes billed under the medical benefit that require PA approval (including CGM): ereferrals.bcbsm.com/docs/common/common-procedure-codes-that-require-prior-auth.pdf

DME

[2] More info on preferred BCBSM DME vendor Northwood: ereferrals.bcbsm.com/docs/common/common-northwood-dmepos-faq.pdf. Information on DME coverage under the medical benefit for BCBSM/BCN commercial and Medicare beneficiaries: ereferrals.bcbsm.com/bcn/bcn-dme-po.shtml

COVERAGE GUIDE

CGMs for Commercial Plans



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PLAN	BENEFIT TYPE	TYPE 2 DIABETES DIAGNOSIS AND		ADDITIONAL DOCUMENTATION	ORDERING
		INSULIN	OR NON-INSULIN CRITERIA		
IF PRESCRIBER IS <u>NOT</u> A CURRENT MCT2D AND PDCM PHYSICIAN MEMBER:				PRIOR AUTH: For DME/medical benefit, submit via Northwood. For pharmacy benefit, use CoverMyMeds. See below BCBSM disclaimers.	
BCBSM Consult individual plans New CGM policy as of 3/1/25 michmed.org/w8nMW	Order through Pharmacy OR DME To verify pharmacy or DME: Patient should call the number on the back of insurance card or log in to member.bcbsm.com	Insulin requiring Verified with claims lookback within 365 days when processed at the pharmacy MCT2D and PDCM prescribers: See previous page for CQI-specific coverage criteria	"Problematic hypoglycemia" defined as EITHER: Level 2: At least TWO events with at least two prior med adjustments and/or modifications to treatment plan (e.g. raising A1C targets) <i>Level 2 defined as glucose less than 54 mg/dL.</i> OR Level 3: At least ONE event <i>Level 3 defined as less than 54 mg/dL with altered mental state and/or physical state requiring third party assistance to treat</i>	For Pharm RX: Complete ePA (CoverMyMeds) For DME: Complete prior authorization via DME supplier. PA review from Northwood, Inc. may be required. For more information, please refer to: ereferrals.bcbsm.com/docs/common/common-northwood-dmepos-faq.pdf	Pharmacy Preferred Models Abbott Freestyle Libre 2, 2 Plus, 3, or 3 Plus; Dexcom G6, G7 ¹ For list of network DME vendors, please visit bcbsm.com/individuals/find-care/ . Use the "Find a Doctor" tool to search for network DME suppliers. ²

*Criteria for pregnant patients: "Pregnant individuals that are not on insulin therapy AND who experience postprandial hyperglycemia as defined by ACOG."

BCBSM Disclaimers and Tips

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Preferred CGM Devices

[1] At \$0 Copay Tier: Dexcom G6 receiver, Dexcom G6 transmitter, Dexcom G7 receiver. Northwood, Inc. does not manage or distribute the Eversense CGM implantable sensor. Requests for authorization for Eversense are reviewed by BCBSM/BCN and should be submitted via e-referral after verification of member eligibility and benefits.

Prior Authorization: Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members. Review patient eligibility through the Eligibility & Benefits Inquiry application within the BCBSM provider portal: www.availity.com.

Step 1: Access application on the Patient Registration menu at the top of the Availity home screen.

Step 2: Use this application to confirm whether the BCBSM/BCN commercial member has Diabetes Supplies covered under their medical (DME) benefit, and to verify whether the member has pharmacy benefit coverage. Procedure codes billed under the medical benefit that require PA approval (including CGM): ereferrals.bcbsm.com/docs/common/common-procedure-codes-that-require-prior-auth.pdf

How to submit pharmacy benefit PA for BCBSM/BCN commercial members: <https://ereferrals.bcbsm.com/bcbsm/bcbsm-drugs-pharm-benefit.shtml>

DME

[2] More info on preferred BCBSM DME vendor Northwood: ereferrals.bcbsm.com/docs/common/common-northwood-dmepos-faq.pdf. Information on DME coverage under the medical benefit for BCBSM/BCN commercial and Medicare beneficiaries: ereferrals.bcbsm.com/bcn/bcn-dme-po.shtml

COVERAGE GUIDE

CGMs for Commercial Plans



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PLAN	BENEFIT TYPE	TYPE 2 DIABETES DIAGNOSIS AND		ADDITIONAL DOCUMENTATION	ORDERING
		INSULIN	OR NON-INSULIN CRITERIA		
HAP (COMMERCIAL) Formulary michmed.org/gdV9P	Order through Pharmacy Tier 0 (Zero Cost)	Insulin Verified with claims lookback within 120 days	Tried and failed at least THREE (3) oral diabetes medications in the last 120 days	PRIOR AUTH: Needed if no insulin, use CoverMyMeds.	Preferred Models Dexcom G6 or G7, Freestyle Libre 2, 2 Plus, 3, or 3 Plus \$0 copay, see preferred vendor Preferred Vendor Pharmacy Advantage
PRIORITY (TRAD & OPTIMIZED) michmed.org/yq299 michmed.org/BA4Kb	Order through Pharmacy	Insulin Verified with RX fill within last 6 months			Preferred Models Freestyle Libre 2, 2 Plus, 3, or 3 Plus; Dexcom G6 or G7
UNITED (COMMERCIAL) michmed.org/nmxYW [1] Note: MCT2D members who are UHC in-network providers can bypass PA and DME. Contact UHC if having prescribing issues, using the MCT2D Prior Auth Provider Escalation form: michmed.org/zRwGW	IF MCT2D ¹ Order through Pharmacy	None T2D Dx is the only requirement for patients with OptumRX, when MCT2D.	If not MCT2D: EITHER: • TWO or more Level 2 hypoglycemia events that persist despite multiple attempts to adjust medication(s) or modify diabetes treatment plan • ONE or more Level 3 hypoglycemic event PLUS • 4x daily testing	PRIOR AUTH: If not MCT2D, submit via Optum RX ePA michmed.org/eWmY5 • T2D Dx • Lab results and office notes from within the last three months • Treatment plan • Current signed physician order • Make and model of the device requested	Preferred Models Abbott Freestyle Libre 2, 2 Plus, 3, or 3 Plus; Dexcom G6 or G7
	If not MCT2D, DME or Pharm acy with PA	3x daily insulin	OR	AND	Preferred Vendors <i>See below</i>
UNITED HEALTH CARE (UHC) PREFERRED DME SUPPLIERS AdaptHealth LLC https://adapthealth.com/ 866-259-1414 Advanced Diabetes Supply https://www.northcoastmed.com/ 1-866-422-4866 Byram Healthcare https://www.byramhealthcare.com/ 1-877-902-9726 Edgepark http://www.edgepark.com/ 1-800-321-0591					



COVERAGE GUIDE

CGM ORDERING: DME or PHARMACY

	DME	PHARMACY	NOTES
MEDICARE PART B	✓		TIP: Patient must be on basal insulin to be covered.
MEDICARE ADVANTAGE			
BCBSM MEDICARE ADVANTAGE		✓*	* Unless Medicare UAW Trust group, use DME
BLUE CARE NETWORK MEDICARE ADVANTAGE		✓	
HAP MEDICARE ADVANTAGE		✓	
MICHIGAN MEDICAID	✓		
BLUE CROSS COMPLETE MEDICAID	✓	✓	Either can be used, no preferred copay. <i>Tip:</i> Less documentation is required for pharmacy.
MOLINA MEDICAID	✓	✓	
COMMERCIAL			
AETNA		✓	
BCBSM/BCN	Patients with ✓ MEDICAL benefit ONLY	Pts with MEDICAL <u>AND</u> ✓ <u>PHARMACY</u> benefit	Check your insurance card or member portal for specific coverage. <i>See instructions below this table.</i>
HAP		✓	
PRIORITY		✓	
UNITED	✓	✓	Either can be used, no preferred copay.

Coverage Check for BCBSM/BCN Commercial Patients

Option 1: Check your insurance card: Look for an “RX” symbol and information for an “RXBIN” and/or “RxGRP.” If present, send CGM prescription to the **pharmacy**.

Option 2: Log into member.bcbsm.com: Then, click on ‘My Coverage.’ Under the “Benefits” heading, look for “**Prescription.**” If present, send CGM prescription to the **pharmacy**. If not, send to **DME**.

Blue Care Network of Michigan

Subscriber Name	Office Visit	\$20
Subscriber ID	Office Visit - Specialist	\$20
Issuer (80840)	Urgent Care	\$50
Group Number	Retail Health Center	\$50
Issued	Deductible (\$)	500 / 1,000
Plan	Out-of-Pocket (\$)	2,750 / 5,500
RxBIN	Individual / Family	
RxGRP		

R



COVERAGE GUIDE DEFINITIONS AND DISCLAIMERS

PREScriBER TIP TO BYPASS PRIOR AUTHORIZATION

Include type 2 diabetes ICD10 code in both the 1.) medical claim for the patient's office visit as well as the 2.) prescription.

For the prescription, look for the "Note to pharmacy" field in Epic (or equivalent field in your EMR). Avoid placing in the "sig" field.

Why? Having T2D diagnosis code in both the prescription and visit claim, can reduce likelihood of PA for some plans. Many insurance plans check coverage requirements using an auto lookback in either medical claims or RX before authorizing coverage.

ICD10 Codes for Type 2 Diabetes

Common list, see full list at
www.aapc.com/codes/icd-10-codes/E11

Without Complications: **E11.9**

Without complications + with insulin: **E11.9, Z79.4**

With hypoglycemia without coma: **E11.649**

With hypoglycemia with coma: **E11.641**

With hyperglycemia: **E11.65**

With diabetic chronic kidney disease: **E11.22**

With unspecified diabetic retinopathy: **E11.31**

With moderate non proliferative diabetic retinopathy:
E11.33

With proliferative diabetic retinopathy: **E11.35**

With diabetic neuropathy, unspecified: **E11.40**

Prescription code add-on to above ICD10 codes

With insulin (Z79.4)

Deductible

Predetermined amount that must be paid annually before insurance pays for anything.

Copayment

Set amount paid for a prescription.

Co-insurance

Amount you pay after your deductible is met. Your insurance pays their portion. Co-insurance only applies to prescriptions and services covered under your health plan.

Medication tier

Levels of insurance medication coverage: You play a smaller amount for a lower tier and a higher amount for a higher tier.

Out-of-pocket max

Annual limit on what you pay before insurance covers 100% of covered services. Deductibles, copayment, and co-insurance all apply toward your out-of-pocket maximum.

Prior authorization

Request made by your health care provider to your insurance company for coverage of a medication.

Quantity limit

Limitation on the amount of medication (# of pills, pens, etc) covered for a period of time.

Step therapy

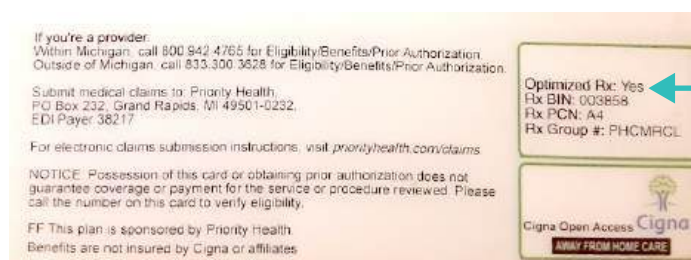
Medication you must have tried prior to approval of a non-preferred medication, typically prior to trying a more expensive medication.

Pharmacy Carve-Out

Some insurance plans allows for pharmacy carve-outs, where prescription drug coverage is provided by a pharmacy benefits manager (PBM) and may not reflect the same coverage as the medical policy's medication formulary.

Do I have a pharmacy carve-out?

Check your insurance ID card. For example, if you have Priority Health, look for "Optimized RX: Yes" on the back of the card





COVERAGE GUIDE

APPENDIX: FORMULARY, STEP THERAPY, PRIOR AUTHORIZATION, DME POLICY LINKS

PAYOR	2025 FORMULARY	ST/PA GUIDELINES	CGM POLICY	PROVIDER PHONE
Medicare	See MA plans	See MA plans	michmed.org/dJ8z3	800-633-4227
MA: Aetna	michmed.org/8NQrk	michmed.org/KqrMw	See Medicare/CMS policy listed above	800-624-0756
MA: BCBSM	michmed.org/DymRY	michmed.org/yqVYZ	michmed.org/PYZgY	800-344-8525 DME: 1-800-447-9599
MA: HAP	michmed.org/WAZqQ	michmed.org/vJV3A	See Medicare/CMS policy listed above	800-292-2550
MA: Humana	michmed.org/kQ894	michmed.org/kQkYr GLP: michmed.org/BnNrm	See Medicare/CMS policy listed above	800-523-0023
MA: Priority	michmed.org/7NVGN	PA: michmed.org/MMxnk ST: michmed.org/QkZxq	See Medicare/CMS policy listed above	800-942-4765
MA: United	michmed.org/YkDR3	n/a	See Medicare/CMS policy listed above	800-711-4555
MA: Wellcare	michmed.org/gRWDV	n/a	See Medicare/CMS policy listed above	855-538-0454
Aetna	michmed.org/97Ay9	michmed.org/KqrMw michmed.org/7kXWr michmed.org/QRQMm	michmed.org/3xAqb	PA 800-414-2386
BCBSM	michmed.org/nmxVD	michmed.org/zRQZB	michmed.org/w8nMW	800-344-8525 DME: 1-800-447-9599
Express Scripts	michmed.org/Dyq2x	michmed.org/3xAey	n/a	888-327-9791
HAP	michmed.org/qdV9P	Use Provider Portal hap.org/providers/provider-resources	michmed.org/WXBmd	888-427-6464
Priority Traditional	michmed.org/yq299	michmed.org/jm85Q	michmed.org/dJzPq	800-942-4765
Priority Optimized	michmed.org/BA4Kb	michmed.org/jm85Q	michmed.org/dJzPq	800-942-4765
United	michmed.org/7NJrY	SGLT2i: michmed.org/Yk9Yb GLP-1 RA: michmed.org/vJmge	michmed.org/nmxYW	800-711-4555
Medicaid	michmed.org/N2wn8	michmed.org/2VP94	michmed.org/Dyeme	800-292-2550
Blue Cross Complete	michmed.org/xNX5W	michmed.org/xNX5W	michmed.org/PJGPA	See region specific #
McLaren	michmed.org/QRr9A	n/a	n/a	888-327-0671
Molina	michmed.org/vJ4rz	michmed.org/JDqXY	michmed.org/gRWVY	855-326-5059