COVERAGE GUIDE
Change Log

Date	Player/Plan	Drug/ Device	Change
			Anti-Obesity Medications
10/01 /24	ExpressScripts PBM	Wegovy	Was “Preferred” now “Preferred **with PA**”
10/01 /24	Michigan Medicaid	Zepbound	Was “Not Covered” now “Preferred with PA”
10/01 /24	Michigan Medicaid	All Anti-Obesity Meds	Prior authorization criteria updated as of 9/1/24 michmed.org/2VP94 with 1. Age limits defined, with age group-specific BMI and health criteria, as well as age group-specific renewal criteria 2. Additional clause for all medications: “For patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatments”
			GLP-1 RA
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.
Effective 11/1/2 024	Michigan Medicaid	GLP-1 RA	Ozempic is now listed as Preferred. Was “Non-Preferred”

COVERAGE GUIDE
Change Log

Date	Player/Plan	Drug/ Device	Change
			GLP-1 RA Medicare Advantage
8/20/24	United Commercial	Bydureon BCise Mounjaro Ozempic Rybelsus Trulicity Victoza	Removed “Trial of metformin” as PA condition and added “or lab results for Dx less than 2 years.” Updated PA for preferred meds now reads: “PA - T2D Dx in RX OR or lab results for Dx less than 2 years.” Revised policy (effective 5/1/24) can be found https://michmed.org/vJmqe
			CGM
8/30/24	Blue Care Network (BCN) Medicare Advantage	CGMs (Abbott Freestyle Libre, Dexcom)	*Beginning October 1, 2024* For dates of service on or after Oct. 1, 2024, Medicare Plus Blue℠ and BCN Advantage℠ members must obtain their continuous glucose monitor products through a participating network pharmacy. Blue Cross Blue Shield of Michigan and Blue Care Network will no longer cover CGM products dispensed by contracted and noncontracted durable medical equipment, or DME, suppliers for Medicare Advantage members. When this change goes into effect on Oct. 1: • Medicare Plus Blue and BCN Advantage members who receive their CGM products through a DME supplier will require a new prescription to be filled at a pharmacy. • Participating pharmacies will be able to dispense CGM products through members’ Part B benefits at point of sale; FreeStyle Libre and Dexcom are the preferred brands. The CGM products will be billed under the members’ medical benefits, not their pharmacy benefits. • Note: Current coverage criteria will still apply.

COVERAGE GUIDE GLP-1 RA / GIP for COMMERCIAL

COMMERCIAL PLAN Formulary Link	MOUNJARO *Tirzepatide* *Injectable - Weekly*	TRULICITY *Dulaglutide* *Injectable - Weekly*	OZEMPIC *Semaglutide (SQ)* *Injectable - Weekly*	RYBELSUS *Semaglutide* *Oral - Daily*	VICTOZA *Liraglutide* *Injectable - Daily*	BYDUREON BCISE *Exenatide* *Injectable - Weekly*
AETNA michmed.org/97Ay9	**Preferred** Bypass PA: ICD10 in RX	**Preferred** Bypass PA: ICD10 in RX	**Preferred** Bypass PA: ICD10 in RX	**Preferred** Bypass PA: ICD10 in RX	**Preferred** Bypass PA: ICD10 in RX	**Not Covered**
BCBSM/BCN michmed.org/nmxVD	**Preferred** Bypass PA: ICD10 in med claim for pt visit	**Preferred** Bypass PA: ICD10 in med claim for pt visit	**Preferred** Bypass PA: ICD10 in med claim for pt visit	**Preferred** Bypass PA: ICD10 in med claim for pt visit	**Preferred** Bypass PA: ICD10 in med claim for pt visit	**Not Covered**[1]
EXPRESS SCRIPTS michmed.org/Dyq2x	**Preferred** PA: T2D dx	**Preferred** PA: T2D dx	**Preferred** PA: T2D dx	**Preferred** PA: T2D dx	**Not Covered**	**Preferred** PA: T2D dx
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	**Preferred Brand** ST: 90-day trial/failure metformin within last 120 days	**Non Formulary**
PRIORITY 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	**Non Formulary** Tier 9
PRIORITY OPTIMIZED michmed.org/BA4Kb	**Preferred** PA[2]	**Preferred** PA[2]	**Not Covered** Tier 9	**Not Covered** Tier 9	**Not Covered** Tier 9	**Not Covered** Tier 9
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	**Preferred** PA ICD10 in RX or labs if DX < 2 years	**Preferred** PA ICD10 in RX or labs if DX < 2 years

1. **Bydureon BCise:** Patient should contact their employer benefits office to determine if their employer elected the BCBSM 'Preferred Drug List' (PDL). If yes, this drug is covered.
2. **Priority Optimized PA for Mounjaro/Trulicity**: 1.Trial and failure, or intolerance to at least 2 generic oral anti-diabetic agents used in combination **OR** insulin after THREE continuous months of receiving maximal daily doses, in conjunction with diet and exercise[3], and not achieving adequate glycemic control (must be within the last SIX months) AND A1c less than or equal to 9%, but not less than 7%.
3. Note for "diet and exercise": 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.

Submit ePA through plan and health system preferred portal e.g. Surescripts portal, CenterX ePA, or CoverMyMeds as applicable.

Find a glossary of ICD10 codes on Page 15.

MCT2D MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

COVERAGE GUIDE GLP-1 RA / GIP for MEDICARE ADVANTAGE

MEDICARE PLAN Formulary Link	MOUNJARO *Tirzepatide* *Injectable - Weekly*	TRULICITY *Dulaglutide* *Injectable - Weekly*	OZEMPIC *Semaglutide (SQ)* *Injectable - Weekly*	RYBELSUS *Semaglutide* *Oral - Daily*	VICTOZA *Liraglutide* *Injectable - Daily*	BYDUREON BCISE *Exenatide* *Injectable - Weekly*
AETNA MA michmed.org/8NQrk	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	Preferred Brand ICD10 in RX **PA**
BCBSM/ BCN MA michmed.org/DymRY See footnote on last page	Preferred Brand Hx of T2D med OR ICD10 in RX	Preferred Brand Hx of T2D med OR ICD10 in RX	Preferred Brand Hx of T2D med OR ICD10 in RX	Preferred Brand Hx of T2D med OR ICD10 in RX	Non Formulary Except for UAW Group	Preferred Brand Hx of T2D med OR ICD10 in RX
HAP MA michmed.org/8NQrk	Preferred Brand ST: Metformin within last 120 days	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 metformin within last 120 days	Not Covered	Non Formulary
HUMANA MA michmed.org/kQ894	Preferred Brand	Preferred Brand	Preferred Brand	Preferred Brand	Preferred Brand	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**	Non-Preferred Trial of Trulicity **PA**	Preferred Brand ICD10 in RX **PA**
UNITED MA AARP Preferred michmed.org/YkDR3	Preferred Brand **PA**	Preferred Brand **PA**	Preferred Brand **PA**	Preferred Brand **PA**	Not Covered	Preferred Brand **PA**
WELLCARE MA** michmed.org/gRWDV	Preferred Brand **PA**	Preferred Brand **PA**	Preferred Brand **PA**	Preferred Brand **PA**	Non-Preferred	Preferred Brand **PA**

****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 15.

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

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**

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

[1]*Generic Farxiga (dapagliflozin) Not Covered*

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

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

COVERAGE GUIDE
SGLT2i for MEDICARE ADVANTAGE

MEDICARE 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 MA michmed.org/8NQrk	Preferred Brand	Preferred Brand	Not Covered	Not Covered	Not Covered
BCBSM/BCN MA michmed.org/DymRY	Preferred Brand	Preferred Brand	Not Covered	Not Covered	Non Formulary
HAP MA michmed.org/8NQrk	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/7NVGN	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

***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

[1]Generic Farxiga (dapagliflozin) Not Covered

COVERAGE GUIDE
GLP-1 RA / GIP AND SGLT2i for MEDICAID

MEDICAID PLAN Formulary Link	MOUNJARO *Tirzepatide* *Injectable - Weekly*	TRULICITY *Dulaglutide* *Injectable - Weekly*	OZEMPIC *Semaglutide (SQ)* *Injectable - Weekly*	RYBELSUS *Semaglutide* *Oral - Daily*	VICTOZA *Liraglutide* *Injectable - Daily*	BYDUREON BCISE *Exenatide* *Injectable - Weekly*	BYETTA *Exenatide* *Injectable - 2x daily*
MICHIGAN MEDICAID michmed.org/N2wn8	Non-Preferred PA	Preferred Brand PA ICD10 in RX or T2D med	Preferred Brand PA ICD10 in RX or T2D med	Non-Preferred PA	Preferred Brand PA ICD10 in RX or T2D med	Non-Preferred PA	Preferred Brand PA ICD10 in RX or T2D med

Find a glossary of ICD10 codes on last page

MEDICAID PLAN Formulary Link	JARDIANCE *Empagliflozin* *Oral - Daily*	FARXIGA *Dapagliflozin* *Oral - Daily*	INVOKANA *Canagliflozin* *Oral - Daily*	STEGLATRO *Ertugliflozin* *Oral - Daily*	BRENZAVVY *Bexagliflozin* *Oral - Daily*
MICHIGAN MEDICAID michmed.org/N2wn8	Preferred Brand	Preferred Brand	Preferred Brand	Non-Preferred PA	Unknown

For most up-to-date PA criteria, see Michigan Medicaid page michmed.org/2VP94 and click on "Drug PA criteria' link.

As of May 1, 2024**, Non-Preferred GLP-1 RAs** (Bydureon Bcise, 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 May 1, 2024**, Non-Preferred SGLTi'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 subgroup.

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

COVERAGE GUIDE
ANTI-OBESITY MEDS for COMMERCIAL

PLAN NAME Formulary Link	SAXENDA *Liraglutide* *Injectable - Daily*	WEGOVY *Semaglutide* *Injectable - Weekly*	ZEPBOUND *Tirzepatide* *Injectable - Weekly*	CONTRAVE *Naltrexone HCl - Buproprion HC* *Oral - 2x Daily*	LOMAIRA *Phentermine 8mg Low Dose* *Oral - Daily w/Meals*	PHENTERMINE *Generic - High Dose* *Oral - Daily w/ Meals*	QSYMIA *Phentermiine - Topiramate* *Oral - Daily*
AETNA michmed.org/97Ay9	Preferred Brand PA[1]	Preferred Brand PA[1]	Non Formulary	Non Formulary	Not Covered	Preferred Generic PA	Preferred Brand PA
BCBSM* michmed.org/nmxVD	Non-Preferred Brand PA[2]	Non-Preferred Brand PA[2]	Non-Preferred Brand PA[2]	Non-Preferred Brand PA[2]	Non-Preferred Brand	Preferred Generic	Non-Preferred Brand PA[2]
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	Not Covered	Not Covered	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	Not Covered	Not Covered	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 PA[3]	Non-Preferred PA[3]	Preferred Generic Tier 1 PA[3]	Non-Preferred PA[3]

1. Aetna PA criteria for Wegovy: michmed.org/QRQMm Quantity Limit (as of 4-1-24): michmed.org/93M3g
2. BCBSM PA criteria for GLP-1 RAs for Weight Loss (see next page), non-GLP-1 RAs, and BCBSM document michmed.org/zRQZ
3. 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

COVERAGE GUIDE

ANTI-OBESITY MEDS for COMMERCIAL

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
POLICY: michmed.org/zRQZB
See also: June 6, 2024 provider alert: michmed.org/Z7eqq
Effective August 1 - December 31, 2024

Current PAs for these three drugs will expire July 31, 2024. Providers must open new PA to continue coverage. Starting January 1, 2025, GLP-1 RA for weight loss will no longer be covered.

1. 18 years or older
2. Initial BMI at first time of prescribing of 35+
3. Must be prescribed by a health care provider who has an established relationship with the member and has seen the member in person. *Provider attestation.*
4. Prescriber must document the member's current baseline weight (within 30 days).
5. Prescriber must document the member's active participation in a lifestyle modification program (working with a coach, tracking food and exercising) for a minimum duration of six months before the PA request. The prescriber will no longer be able to attest to a member's participation. The prescriber must submit documentation, or the request will be denied. *Provider attestation.*
6. Patient must enroll and participate in the **Teladoc® Health program** for weight management. This is a program at no cost to eligible members that offers easy-to-use tools and support. The prescriber must submit documentation of the member's active participation, or the request will be denied.
7. Can't be used in combination with other weight loss products or other products that contain GLP-1 agonists
8. Aren't covered for members with type 2 diabetes

MEDICATION: Contrave, Qsymia

1. Age ≥ 18 years old
2. BMI ≥ 30, or ≥ 27 with one weight related comorbid 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

COVERAGE GUIDE

ANTI-OBESITY MEDS for Medicare Advantage

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

ANTI-OBESITY MEDS for Medicaid

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

Michigan Medicaid PDL Magellan 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 September 1, 2024)

INITIAL RX (6 MONTHS)

Age and BMI:

1. *Wegovy, Saxenda:* Patient age ≥12 years **OR**
2. *Phentermine:* Patient age > 16 years **AND**
   a. 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**
   b. 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; **OR**
3. *Zepbound*: Patient age ≥18 years **AND**
   a. Patient age ≥18 years must have an initial body mass index [BMI] ≥ than 30 kg/m² ; **OR**
   b. Patient age ≥18 years must have an initial body mass index [BMI] ≥ than 27 kg/m² but <30 kg/m² and at least one of the following risk factors: hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea

Additionally:

1. 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**
2. 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**
3. 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**
4. Prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability; **AND**
5. Prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet a

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

RENEWAL RX (6 MONTHS)

1. For adults age ≥18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of ≥ 5% from baseline weight at initiation of therapy.
2. For patient's age ≥12 years to <18 years, prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy.

COVERAGE GUIDE
CGMs for Medicare/Advantage 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		
MEDICARE Part B michmed.org/dJ8z3	**DME**	**Insulin treated**	**"Problematic hypoglycemia"** defined as ***EITHER***: **Level 2** at least **TWO** that persist *despite* **at least two** prior med adjustments and/or modifications to treatment plan (e.g. raising A1c targets) **OR** **Level 3** history of **ONE** event --- *Level 2* defined as glucose less than 54 mg/dL *Level 3* defined as less than 54 mg/dL *with* altered mental and/or physical state requiring third party assistance to treat	1. **Visit for T2D Mgmt:** Within 6 months (virtual or in-person) 2. **CGM training:** Pt or caregiver has received appropriate training. 3. **FDA indication for use:** For diabetes treatment decisions	**DME Preferred Models** Abbott Freestyle Libre 2 or 3*, Dexcom, and Medtronic **If pt does not have a Libre 2 reader and does not need a standalone reader*
Blue Care Network (BCN) MA	**Beginning Oct 1, 2024 Pharm RX** *Billed under Medical*	**Same as Medicare Part B**	**Same as Medicare Part B**	**Starting 10/1/2024, submit PA through pharmacy. See BCBSM Disclaimer on last page of CGM guide.** **Same as Medicare Part B**	**Pharmacy Preferred Model** Abbott Freestyle Libre*, Dexcom **If pt does not have a Libre 2 reader and does not need a standalone reader*
HAP MA	**Pharm RX**	**Insulin** Verified with claims lookback within 180 days	**3+ non-insulin oral medications** **AND Uncontrolled A1c**	**If no insulin, submit PA via CoverMyMeds.**	**Preferred Models** Dexcom G6 or G7, Freestyle Libre 2 or 3 $0 copay, see preferred vendor **Preferred Vendor** Pharmacy Advantage
United MA - SEE UNITED COMMERCIAL CRITERIA *(LAST PAGE OF CGM GUIDE)*					

COVERAGE GUIDE
CGMs for Medicaid Plans

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

PLAN policy url	BENEFIT TYPE	TYPE 2 DIABETES DIAGNOSIS AND INSULIN	OR	NON-INSULIN CRITERIA	ADDITIONAL DOCUMENTATION	ORDERING
MICHIGAN MEDICAID michmed.org/Dyeme	**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	**Submit PA via 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** *1st order:* Written for 6 months. *2nd order:* Written for 6 months. **Year 2** *Orders:* Written for 12 months.	**Preferred Models** Abbott Freestyle Libre 2 or 3*, 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	**Pharm RX** (or DME)					
Blue Cross Complete (Medicaid) michmed.org/PJGPA	**Pharm RX** (or DME)	**Insulin treated**	*OR*	**Treatement 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%**	**Submit PA via 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 or 3, 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 policy url	BENEFIT TYPE & PA STATUS	TYPE 2 DIABETES DIAGNOSIS AND INSULIN	OR	NON-INSULIN CRITERIA	ADDITIONAL DOCUMENTATION	ORDERING
AETNA Formulary michmed.org/97Ay9	Pharm RX	**Not required**		Only "Clinician's recognition of BENEFIT to patient." No T2D Dx required.		**Preferred Devices** Dexcom G6/G7
BCBSM *Consult individual plans* **New MCT2D-specific CGM policy as of 6/1/24** michmed.org/AnjzA	**IF PRESCRIBER IS A CURRENT MCT2D AND PDCM PHYSICIAN MEMBER:** (AS OF JUNE 1, 2024) Pharm RX DME	**Not required**		**None**	**For DME/medical benefit: Submit PA via Northwood.** ***See below BCBSM disclaimers.^*** **Prescribing physician** must attest to being a current physician member of MCT2D or PDCM **For Pharm RX:** No PA required for MCT2D physicians **For DME:** PA auto-approved for MCT2D phsyciains	**Pharmacy Preferred Models** Abbott Freestyle Libre 2, Libre 3, Dexcom G6, G7** For list of preferred DME vendors and covered CGMs, please contact Northwood, Inc.

*Criteria for pregnant patients: "Pregnant individuals that are not on insulin therapy AND who experience postprandial hyperglycemia as defined by ACOG."
** At $0 Copay Tier: Dexcom G6 receiver, Dexcom G6 transmitter, Dexcom G7 receiver

^BCBSM Disclaimers and Tips

- Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members
- Review member eligibility through the Eligibility & Benefits Inquiry application within the BCBSM provider portal: www.availity.com
  1. Access application on the Patient Registration menu at the top of your Availity home screen.
  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.
- Information on DME coverage under the medical benefit for BCBSM/BCN commercial and Medicare beneficiaries: https://ereferrals.bcbsm.com/bcn/bcn-dme-po.shtml
- Procedure codes billed under the medical benefit that require PA approval (including CGM): https://ereferrals.bcbsm.com/docs/common/common-procedure-codes-that-require-prior-auth.pdf
- More info on preferred BCBSM DME vendor Northwood: https://ereferrals.bcbsm.com/docs/common/common-northwood-dmepos-faq.pdf
- **How to submit pharmacy benefit PA** for BCBSM/BCN commercial members: https://ereferrals.bcbsm.com/bcbsm/bcbsm-drugs-pharm-benefit.shtml
- 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.

COVERAGE GUIDE
CGMs for Commercial Plans

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

PLAN policy url	BENEFIT TYPE & PA STATUS	TYPE 2 DIABETES DIAGNOSIS AND INSULIN	OR	NON-INSULIN CRITERIA	ADDITIONAL DOCUMENTATION	ORDERING
BCBSM *Consult individual plans* New CGM policy as of 3/1/24 michmed.org/w8nMW	**IF PRESCRIBER IS NOT A CURRENT MCT2D AND PDCM PHYSICIAN MEMBER:** (AS OF JUNE 1, 2024)					
	Pharm RX **DME**	**Insulin requiring**		**"Problematic hypoglycemia"** defined as EITHER:* **Level 2:** At least TWO events *with* at least tow prior med adjustments and/or modifications to treatement plan (e.g. raising A1C targets) *Level 2 defined as glucose less than 54 mg/dL.* **OR** **Level 3:** At least ONE event *Level 3 defined as less than 54 mg/dL with altered mental state and/or physical state requiring third party assistance to treat*	**For DME/medical benefit: Submit PA via Northwood.** **For pharmacy benefit: Submit PA via CoverMyMeds.** ***See below BCBSM disclaimers.^*** **For Pharm RX:** Complete ePA (CoverMyMeds) **For DME:** Complete prior authorization via DME supplier, processed by Northwood, Inc	

*Criteria for pregnant patients: "Pregnant individuals that are not on insulin therapy AND who experience postprandial hyperglycemia as defined by ACOG."
** At $0 Copay Tier: Dexcom G6 receiver, Dexcom G6 transmitter, Dexcom G7 receiver

^BCBSM Disclaimers and Tips

- Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members
- Review member eligibility through the Eligibility & Benefits Inquiry application within the BCBSM provider portal: www.availity.com
  1. Access application on the Patient Registration menu at the top of your Availity home screen.
  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.
- Information on DME coverage under the medical benefit for BCBSM/BCN commercial and Medicare beneficiaries: https://ereferrals.bcbsm.com/bcn/bcn-dme-po.shtml
- Procedure codes billed under the medical benefit that require PA approval (including CGM): https://ereferrals.bcbsm.com/docs/common/common-procedure-codes-that-require-prior-auth.pdf
- More info on preferred BCBSM DME vendor Northwood: https://ereferrals.bcbsm.com/docs/common/common-northwood-dmepos-faq.pdf
- **How to submit pharmacy benefit PA** for BCBSM/BCN commercial members: https://ereferrals.bcbsm.com/bcbsm/bcbsm-drugs-pharm-benefit.shtml
- 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.

COVERAGE GUIDE
CGMs for Commercial Plans

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

PLAN policy url	BENEFIT TYPE & PA STATUS	TYPE 2 DIABETES DIAGNOSIS AND INSULIN	OR	NON-INSULIN CRITERIA	ADDITIONAL DOCUMENTATION	ORDERING
HAP *(COMMERCIAL)* Formulary michmed.org/gdV9P	**Pharm RX** 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	**If no insulin, submit PA via CoverMyMeds.**	**Preferred Models** Dexcom G6 or G7, Freestyle Libre 2 or 3 $0 copay, see preferred vendor **Preferred Vendor** Pharmacy Advantage
PRIORITY *(TRAD & OPTIMIZED)* michmed.org/yq299 michmed.org/BA4Kb	**Pharm RX**	**Insulin** Verified with RX fill within last 6 months				**Preferred Models** Freestyle Libre 2 or 3,, Dexcom G6 or G7
UNITED *(COMMERCIAL)* michmed.org/nmxYW	**If MCT2D Pharm RX** See note below	**None** **T2D Dx** is only requirement for patients with OptumRX.		**If not MCT2D:** • 4x daily testing • Frequent adjustments to treatment based on testing • Compliance to physician-directed comprehesive diabetes mgmt program • Assessed every 6 months	**If not MCT2D, submit PA 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 or 3, Dexcom G6 or G7
	If not MCT2D, DME with PA	**3x daily insulin**				**Preferred Vendors** *See below*

UNITED HEALTH CARE (UHC) PREFERRED DME SUPPLIERS

AdaptHealth LLC	Advanced Diabetes Supply	Byram Healthcare	Edgepark
https://adapthealth.com/ 1-844-727-6667	https://www.northcoastmed.com 1-866-422-4866	https://www.byramhealthcare.com/ 1-877-902-9726	http://www.edgepark.com/ 1-800-321-0591

Note: MCT2D members who are UHC in-network providers can bypass PA and DME. Contact UHC if having prescribing issues, use this form: michmed.org/zRwGW

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.

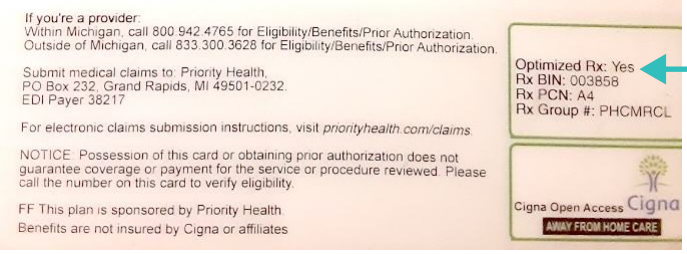
Quantity limit
Limitation on the amount of medication (# of pills, pens, etc) covered for a period of time.

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



MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

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

PAYOR	2024 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	See Medicare/CMS policy listed above	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	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	n/a	888-427-6464
Priority *Traditional*	michmed.org/yq299	michmed.org/jm85Q	michmed.org/dJzPq	800-942-4765
Priority *Opimized*	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/vJmqe	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	n/a	michmed.org/gRWVY	855-326-5059