Change Log

Date	Payer	Drug/Device	Change
12/11/23	Priority	**CGM**	Correction on abbreviated guide: Changed from "Criteria: T2D diagnosis" to "Criteria: T2D diagnosis **AND insulin RX**"
10/30/23	Medicaid	**Contrave**	New info: No longer covered, as of Oct 1, 2023
10/4/23	HAP Medicare Advantage	**Mounjaro**	New info: Changed from "No Info" to "Preferred Brand"
10/4/23	Wellcare Medicare Advantage	**Mounjaro**	New info: Changed from "No Info" to "Non Formulary"
10/4/23	United Medicare Advantage	**CGM**	New info: Added "180 day" to insulin claims auto lookback
10/4/23	Aetna	**CGM**	Coverage expansion: Covered under Pharmacy benefit. Criteria is "unrestricted": Dx of diabetes or clinician recognition of the benefit
10/4/23	McLaren Medicaid	**CGM**	Fixed: Coverage is DME *not* Pharmacy. Dexcom removed as Preferred Brand.
10/4/23	Blue Cross Complete	**CGM**	Coverage expansion: Dexcom G7 added to list of preferred devices
10/4/23	BCBSM	**Anti-Obesity Meds**	Prior authorization criteria have changed (10/1/2023). See document: https://michmed.org/zRQZB

What's New in this Guide

Last updated 30 October 2023
v2023.3.3

Date	Payer	Drug/Device	Change
10/4/23	Medicaid	**Byetta Trulicity Victoza**	New info: Effective November 1, 2023, PA criteria for preferred GLP-1 RAs has changed: • Patient has a diagnosis of type 2 diabetes; AND Discontinuation of other GLP-1 agonists
10/4/23	Medicaid	**Bydureon Bcise Mounjaro Ozempic Rybelsus**	New info: Effective November 1, 2023, PA criteria for non- preferred GLP-1 RAs has changed: • Discontinuation of other GLP-1 agonists • Remove the Ozempic medication-specific PA criteria. • Add quantity limits to each agent in accordance with the FDA approved maximum dosing
9/5/23	Aetna	**Mounjaro**	Changed from "Not covered" to "Preferred"
9/1/23	BCBM/BCN Medicare	**GLP-1 RAs**	PA criteria for first time GLP-1 RA Rx has changed: Must have T2D diagnosis. Read more here: https://providerinfo.bcbsm.com/documents/alerts/2023/202308/alert-20230818-9-1-req-prior-auth-some-diabetes-drugs.pdf
8/31/23	Aetna	**phentermine**	Changed from "Not covered" to "Preferred with PA"
8/31/23	Express Scripts	**phentermine**	Changed from "Not covered" to "Preferred"
8/31/23	Blue Cross Complete	**CGM**	FIXED: Added Pharmacy Benefit policy effective 8/1/22, including preferred devices and criteria for non-insulin treated T2D

Change Log

Date	Payer	Drug/Device	Change
8/27/23	Aetna Commercial	**Preferred GLP-1 and SGLT2**	Removed "Prior authorization" not noted in most recent 2023 Formulary
8/27/23	Aetna Commercial	**Mounjaro**	Changed from "Not Covered" to "Non preferred"
8/10/23	Molina Medicaid	**CGM**	Added CGM pharmacy criteria for Molina-managed Medicaid with criteria for CGM pharmacy benefit coverage
8/10/23	Molina Medicaid	**CGM**	Added CGM pharmacy criteria for Molina-managed Medicaid with criteria for CGM pharmacy benefit coverage
8/10/23	Michigan Medicaid	**CGM**	FIXED: Removed "2x daily insulin" as a requirement, error. **Thank you for reporting the error**
8/10/23	United Medicare Advanage	**CGM**	Added CGM pharmacy benefit criteria for United-managed MA plans. **Thank you for reporting this**
8/10/23	All Plans	**CGM**	Simplified the style of the CGM criteria table to increase clarity on T2D, Insulin, and additional criteria requirements for CGM coverage. **Thank you for your feedback!**

PRIVATE PLANS
Coverage for GLP-1 RA & GIP

USE CO-PAY COUPON

	TRULICITY Dulaglutide *Injectable - Weekly*	OZEMPIC Semaglutide *Injectable - Weekly*	RYBELSUS Semaglutide *Oral - Daily*	VICTOZA Liraglutide *Injectable -Daily*	MOUNJARO Tirzepatide *Injectable - Weekly*	BYDUREON BCISE Exenatide *Injectable - Weekly*
AETNA	Preferred	Preferred	Preferred	Preferred	Preferred	Preferred
BCBSM	Preferred Hx: T2D diagnosis or diabetes med	Preferred Hx: T2D diagnosis or diabetes med	Preferred Hx: T2D diagnosis or diabetes med	Preferred Hx: T2D diagnosis or diabetes med	Preferred Hx: T2D diagnosis or diabetes med	Not Covered
EXPRESS SCRIPTS National Preferred	Preferred	Preferred	Preferred	Not Covered	Preferred	Preferred
HAP	Preferred metformin RX within 120 days or CVD risk	Preferred metformin RX within 120 days or CVD risk	Preferred ST Trial or CI Metformin	Preferred metformin RX within 120 days or CVD risk	Preferred ST Trial or CI Metformin	Not Covered
PRIORITY	Preferred T2D ICD-10 Code	Preferred T2D ICD-10 Code	Not Covered	Preferred	Preferred T2D ICD-10 Code	Non Preferred ST Must first try Trulicity, Bydureon, or Byetta
PRIORITY (OPTIMIZED)	Preferred PA See PA criteria below	$$$$$$ Specialty PA ST	Not Covered	$$$$$$ Specialty PA ST	Preferred PA See PA criteria below	$$$$$$ Specialty PA
UNITED	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin	Preferred PA ST Trial or CI Metformin

BYDUREON BCISE - Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

PA **Prior Auth**

ST **Step Therapy**

Claims Autolookback for specific Dx or Rx. If not *present, will trigger PA*

See last page of guide for links to available prior auth and step therapy documentation

Information based on general formularies, unless otherwise noted and may not reflect employer-group specific policies and plans with pharmacy carve outs.

Priority Optimized--Trulicity and Mounjaro are PREFERRED. For others, must meet criteria:
1.Trial and failure, or intolerance to at least 2 generic oral antidiabetic agents used in combination OR insulin after 3 continuous months of receiving maximal daily doses, n conjunction with diet and exercise, and not achieving adequate glycemic control (must be within the last 6 months).
2. Hemoglobin A1c less than or equal to 9%, but not less than 7% and trial and failure or intolerance/CI to bothTrulicity and Mounjaro for 3 continuous months of max dose and not achieving adequate glycemic control

MEDICARE ADVANTAGE

Coverage for GLP-1 RA & GIP

Use PATIENT ASSISTANCE PROGRAMS

Recommended

	TRULICITY Dulaglutide *Injectable - Weekly*	OZEMPIC Semaglutide *Injectable - Weekly*	RYBELSUS Semaglutide *Oral - Daily*	VICTOZA Liraglutide *Injectable -Daily*	MOUNJARO Tirzepatide *Injectable - Weekly*	BYDUREON BCISE Exenatide* *Injectable - Weekly*
AETNA MA	Preferred	Preferred	Preferred	Preferred	Non Formulary	Preferred
BCBSM/BCN MA	Preferred Hx: T2D diagnosis or diabetes med	Preferred Hx: T2D diagnosis or diabetes med	Preferred Hx: T2D diagnosis or diabetes med	Preferred Hx: T2D diagnosis or diabetes med	Non Formulary	Preferred Hx: T2D diagnosis or diabetes med
HAP MA	Preferred ST	Preferred ST	Preferred ST	Preferred ST	Preferred Brand	Non Formulary
HUMANA MA	Preferred	Preferred	Preferred	Preferred	Preferred	$$$$$ Not Preferred
PRIORITY MA	Preferred	$$$$$ Non Preferred ST	Non Formulary	$$$$$ Non Preferred ST	Preferred	Preferred
UNITED AARP (PPO)	Preferred	Preferred	Preferred	Preferred	Preferred	Preferred
WELLCARE MA	Preferred	Preferred	Preferred	Preferred	Non Formulary	Preferred

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

ST **Step Therapy**

See last page of guide for links to available prior auth and step therapy documentation

PRIVATE PLANS

Coverage for SGLT2i

Use COPAY COUPON PROGRAMS

Recommended

	JARDIANCE Empagliflozin *Oral - Daily*	FARXIGA Dapagliflozin *Oral - Daily*	INVOKANA Canagliflozin *Oral - Daily*	STEGLATRO Ertugliflozin *Oral - Daily*
AETNA	Preferred Brand	Preferred Brand	Not Covered	Not Covered
BCBSM	Preferred	Preferred	Not Covered	Not Covered
EXPRESS SCRIPTS National Preferred	Preferred	Preferred	Not Covered	Preferred
HAP	Preferred	Preferred	Not Covered	Not Covered
PRIORITY	Preferred	Preferred	Non Preferred ST Must first try Farxiga OR Jardiance	Non Preferred ST Must first try Farxiga OR Jardiance
PRIORITY (OPTIMIZED)	Preferred	Preferred	Non Preferred ST Must first try Farxiga OR Jardiance	Non Preferred ST Must first try Farxiga OR Jardiance
UNITED	Preferred	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY michmed.org/Yk9Yb	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY michmed.org/Yk9Yb	Not Covered

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

ST

Step Therapy

See last page of guide for links to available prior auth and step therapy documentation

MEDICARE ADVANTAGE

Coverage for **SGLT2i**

Use PATIENT ASSISTANCE PROGRAMS

Recommended

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

	JARDIANCE Empagliflozin *Oral - Daily*	**FARXIGA** Dapagliflozin *Oral - Daily*	**INVOKANA** Canagliflozin *Oral - Daily*	**STEGLATRO** Ertugliflozin *Oral - Daily*
AETNA MA	Preferred Brand	Preferred Brand	Not Covered	Not Covered
BCBSM/BCN MA	Preferred Brand	Preferred Brand	Not Covered	Not Covered
HAP MA	Preferred Brand	Preferred Brand	Not Covered	Not Covered
HUMANA MA	Preferred Brand	$$$$$$ Non-Preferred	Preferred Brand	Not Covered
PRIORITY MA	Preferred Brand	Preferred Brand	Non Preferred ST Must first try Farxiga, Xigduo, Jardiance or Synjardy	Non Preferred ST Must first try Farxiga, Xigduo, Jardiance or Synjardy
UNITED AARP (PPO)	Preferred Brand	Preferred Brand	Not Covered	Not Covered
WELLCARE MA	Preferred Brand	Preferred Brand	$$$$$$ Non Preferred *Try preferred 1st*	Not Covered

ST

Step Therapy

See last page of guide for links to available prior auth and step therapy documentation

MEDICAID

COVERAGE for GLP-1 RA & GIP

Recommended

	TRULICITY	OZEMPIC	RYBELSUS	VICTOZA	MOUNJARO	BYDUREON BCISE	BYETTA
	Dulaglutide *Injectable - Weekly*	Semaglutide *Injectable - Weekly*	Semaglutide *Oral - Daily*	Liraglutide *Injectable -Daily*	Tirzepatide *Injectable - Weekly*	Exenatide* *Injectable - Weekly*	Exenatide* *Injectable - 2x Daily*
MEDICAID State and Managed	Preferred Hx: T2D Dx or T2D med	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA	Preferred Hx: T2D Dx or T2D med	$$$$$$ Non-Preferred PA	$$$$$$ Non Preferred PA	Preferred Hx: T2D Dx or T2D med

Effective 8/1/23, Non-Preferred PA criteria for Medicaid:

Diagnosis of type 2 diabetes; **AND**

- Allergy to the preferred medications; **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- Trial and failure with one preferred medication within same subgroup. If **Ozempic**, additional criteria below:
- Trial and failure of a Preferred Medication is not required for members already established on Ozempic as it is indicated for both improved cardiovascular outcomes and once weekly administration.

Michigan Medicaid Managed plans include

Aetna: https://michmed.org/KqzA9

Blue Cross Complete of Michigan: https://michmed.org/MMQGm

HAP CareSource: https://michmed.org/2VbqN

McLaren Health Plan: https://michmed.org/3xb7v

Meridian: https://michmed.org/RRYQg

Molina Healthcare: https://michmed.org/w8jy5

Priority Health: https://michmed.org/vJwDR

United Healthcare: https://michmed.org/jmqw5

Upper Peninsula Health Plan: https://michmed.org/ZwRWA

MEDICAID

COVERAGE for SGLT2i

Recommended

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

	JARDIANCE	FARXIGA	INVOKANA	STEGLATRO
	Empagliflozin *Oral - Daily*	Dapagliflozin *Oral - Daily*	Canagliflozin *Oral - Daily*	Ertugliflozin *Oral - Daily*
MEDICAID State and Managed	Preferred	Preferred	Preferred	$$$$$$ Non-Preferred PA

COVERAGE for GLP-1 RA & GIP

Recommended

	TRULICITY	OZEMPIC	RYBELSUS	VICTOZA	MOUNJARO	BYDUREON BCISE	BYETTA
	Dulaglutide *Injectable - Weekly*	Semaglutide *Injectable - Weekly*	Semaglutide *Oral - Daily*	Liraglutide *Injectable -Daily*	Tirzepatide *Injectable - Weekly*	Exenatide* *Injectable - Weekly*	Exenatide* *Injectable - 2x Daily*
MEDICAID State and Managed	**Preferred** Hx: T2D Dx AND Discontinuation of other GLP-1 RAs PA	$$$$$$ **Non-Preferred** PA	$$$$$$ **Non-Preferred** PA	PA	$$$$$$ **Non-Preferred** PA	$$$$$$ **Non Preferred** PA	

COVERAGE for SGLT2i

Recommended

	JARDIANCE	FARXIGA	INVOKANA	STEGLATRO
	Empagliflozin *Oral - Daily*	Dapagliflozin *Oral - Daily*	Canagliflozin *Oral - Daily*	Ertugliflozin *Oral - Daily*
MEDICAID State and Managed	**Preferred**	**Preferred**	**Preferred**	$$$$$$ **Non-Preferred** PA

Lacks evidence for renal and CVD outcomes. Refer to current clinical guidelines for more data.

PRIVATE PLANS
COVERAGE for Anti-Obesity Meds

	SAXENDA Liraglutide *Injectable - Daily*	WEGOVY Semaglutide *Injectable - Weekly*	PHENTERMINE Generic - High Dose *Oral - Daily w/ Meals*	LOMAIRA Phentermine 8 Low Dose *Oral - Daily w/ Meals*	QSYMIA Phentermine - Topiramate *Oral - Daily*	CONTRAVE Naltrexone HCl - Bupropion HC *Oral - 2x Day*
AETNA	Preferred PA	Preferred PA	Preferred PA	Not Covered	Preferred	Not Covered
BCBSM*	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA	Preferred	$$$$$$ Non-Preferred	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA
EXPRESS SCRIPTS National Preferred	$$$$$$ Non-Preferred PA	Preferred PA	Preferred PA	Preferred	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA
HAP	Not Covered	Not Covered	Preferred	Not Covered	$$$$$$ Non-Preferred PA	Not Covered
PRIORITY (TRADITIONAL)	Not Covered	Not Covered	Preferred	$$$$$$ Non-Preferred ST Must try generic first	$$$$$$ Non-Preferred** ST Must try generic first	$$$$$$ Non-Preferred ST Must try generic first
PRIORITY (OPTIMIZED)	Not Covered	Not Covered	Preferred	Not Covered	$$$$$$ Non-Preferred ST Must try generic first	$$$$$$ Non-Preferred ST Must try generic first
UNITED	Not Covered	Not Covered	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY	Not Covered	Not Covered May be excluded from coverage or subject to PA in CT, NJ and NY

PA **Prior Auth**

ST **Step Therapy**

See last page of guide for links to available prior auth and step therapy documentation

Disclaimer: Information based on general formularies, unless otherwise noted and may not reflect employer-group specific policies and plans with pharmacy carve outs.

**Priority coverage for Qsymia determined by: "Employers plan rider determines weight loss coverage"

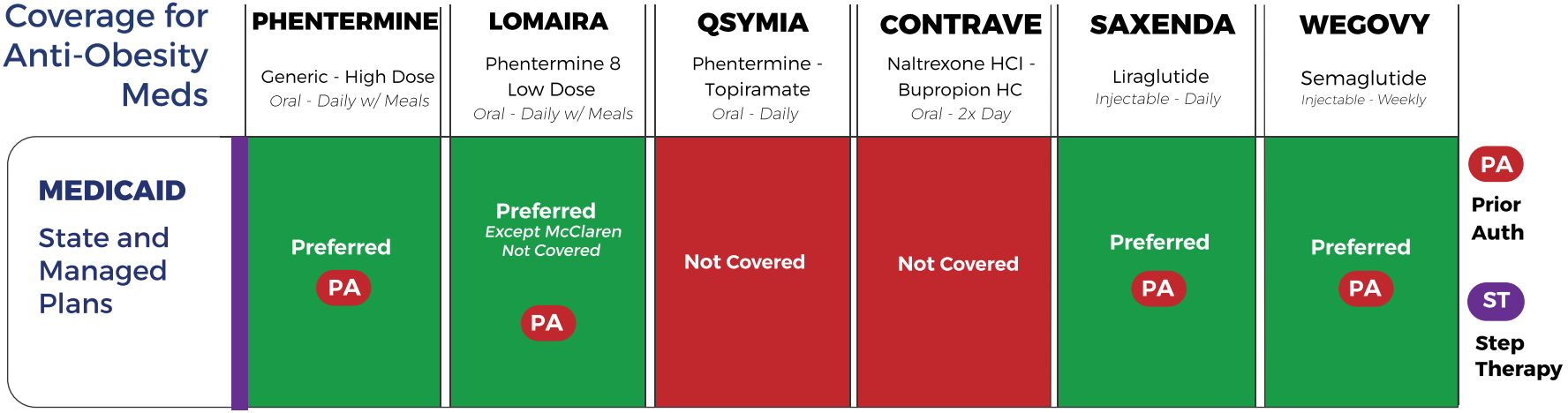
MEDICARE ADVANTAGE

Coverage for Anti-Obesity Meds

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

MEDICAID

Coverage for Anti-Obesity Meds



Michigan Medicaid PDL Magellan RX Prior Auth Criteria:
See michmed.org/2VP94

- Patient must have a body mass index [BMI] ≥ than 30 kg/m2 ; **OR**
- Patient must have a 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; **OR**
- For Wegovy, pediatric patients must have an initial BMI at the 95th percentile or greater for age and sex (obesity); **AND**
- Patient age ≥12 years (Wegovy, Xenical, Saxenda); OR
- Patient age ≥18 years (benzphetamine, diethylpropion, phentermine, phendimetrazine); **AND**
- Prescriber attests to patient's absence of any contraindications to use requested product; **AND**
- Prescriber attests that the patient is not pregnant or lactating; **AND**
- Prescriber attests that at least one previously documented weight reduction attempt in the past year; **AND**
- Prescriber attests medication therapy is part of a total treatment plan including a calorie and fat restricted diet and exercise and/or activity regimen, as appropriate for the patient's ability

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

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE: Medicare and Medicare Advantage (MA)

See an error in this document? Let us know: ccteam@mct2d.org

	Coverage: Pharm or DME?	1 Requirement: Diabetes Dx	2 Requirement: Insulin Rx	3 Requirements: Other & Notes
Public Plans: Medicare **Medicare & Medicare Advantage**	**DME** Preferred Brand(s) **Abbott Freestyle Libre, Dexcom**	**1. Diabetes diagnosis required**	**2. Insulin treated** **OR** **Have a history of problematic hypoglycemia** ***Definition of "problematic hypoglycemia":*** *Either:* *1. AT LEAST TWO Level 2 hypoglycemic events (<54mg/dL), with AT LEAST TWO previous med adjustments and/or modifications to the treatment plan prior to the most recent Level 2 event* *OR* *2. AT LEAST ONE Level 3 hypoglycemic event (<54 mg/dL), associated with "altered mental and/or physical state", with documentation in EMR that the pt required third party assistance for treatment.*	**Must have in-person or Medicare approved virtual visit in past 6 months for diabetes management** Clinician must also document: 3. The beneficiary (or the beneficiary's caregiver) has received appropriate training in the use of the device as evidenced by an RX. 4. The CGM is being prescribed in accordance with FDA indications for use. Device must have standalone reader (not just smart phone app) to qualify for Medicare DME. MCT2D members recommend Parachute Health ePrescribing platform.
United MA Like AARP PPO	**Pharm** Preferred Brand(s) **Abbott Freestyle Libre, Dexcom**	**1. Diabetes diagnosis required** 180-day Claims Auto Lookback		**Fun Fact** *Worried about the Medicare 'Donut Hole'?* CGMs are covered under Part B (Medical) *not* Part D, even when fulfilled through a pharmacy.

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE: Medicaid

See an error in this document? Let us know: ccteam@mct2d.org

Public Plans Medicaid	Coverage: Pharm or DME?	1 Requirement: Diabetes Dx	2 Requirement: Insulin Rx	3 Requirements: Other & Notes
Medicaid	**DME** Preferred Brand(s) **Abbott Freestyle Libre, Dexcom** PA **PA Required**		**2. Requires the "administering of insulin or is currently using an insulin pump"**	3. Must be under the care of an endocrinology, physician, or non-physician practitioner (NP, PA, or clinical nurse specialist), who is managing their t2d 4. The beneficiary or their caregiver is educated on the use of the device and is willing and able to use the CGM. Documentation must be less than 90 days old. The initial order must be written for six months. If the beneficiary continues to utilize the CGMS, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters and other separately billed supplies used with the CGMS (following frequency rules) may be written for a 12-month period. 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 and Healthy Michigan Plans *Molina-Managed Medicaid*	**Pharm** *(see right)* **or DME** *(see Medicaid criteria above)* Preferred Devices: **Abbott Freestyle Libre 2 or 3, Dexcom G6** PA **Faxed or ePA required**	**1. Diabetes diagnosis required**	**2. "Insulin Dependent" diabetes diagnosis required**	3. Prescriber attests that member/caregiver is scheduled to (within 30 days) or has historical completion (within the last 12 months) of training and support for the CGM device AND member/caregiver has the ability to perform self-monitoring of blood glucose in order to calibrate the monitor if needed and/or verify readings if discordant from their symptoms 4. Prescriber attests member and/or caregiver has been counseled on potential drugs/substances that can falsely raise or lower CGM glucose levels such as APAP, ASA, vitamin C, etc.

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE: Medicaid (cont)

See an error in this document? Let us know: ccteam@mct2d.org

	Coverage: Pharm or DME?	1 Requirement: Diabetes Dx	2 Requirement: Insulin Rx	3 Requirements: Other & Notes
Public Plans Medicaid				
Blue Cross Complete *BCBSM-managed Medicaid*	**Pharm or DME** Preferred Brand(s) Freestyle Libre 14 Day, Freestyle Libre 2, FreeStyle Libre 3, Dexcom G6 or G7 PA	**1. Diabetes diagnosis required**	**2. Treatment with insulin** **OR** Treatment of Type 2 diabetes with an **antihyperglycemic drug without insulin** *AND* one of the criteria (right):	*One of the following must be met IF no insulin:* a. Frequent hypoglycemia, hypoglycemia unawareness, or concerns of nocturnal hypoglycemia b. Gaining weight (more than 5 pounds of weight gain in the last 12 months) c. HbA1C ≥ 7% d. Need for medication changes or titration e. Initiation of a lower carbohydrate diet f. Patient is unable or reluctant to test their blood glucose via traditional glucometer. g. Patient is taking two or more medications to manage their diabetes. h. Patient works with a care team member to improve diet and exercise choices. **With treatment of Type 2 Diabetes and no insulin** * Documentation of positive clinical response (i.e. improved HbA1C or reduced frequency of severe hypoglycemia episodes) *Effective 8/1/2022*
McLaren Medicaid	**DME** PA	**1. Diabetes diagnosis required**	**Refer to Medicaid requirements**	**Refer to Medicaid requirements**

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE: Commercial Plans

See an error in this document? Let us know: ccteam@mct2d.org

	Coverage: Pharm or DME?	1 Requirement: Diabetes Dx	2 Requirement: Insulin Rx	3 Requirements: Other & Notes
Commercial Plans				
Aetna	**Pharm** Preferred Brand(s) **Dexcom**			**Clinician's recognition of benefit to pt** *(no T2D Dx required)*
BCBSM *Consult Individual Plans*	**Pharm** **DME** Preferred Brand(s) **Dexcom** *Receiver & transmitter at $0 cost share* **Abbott Freestyle Libre**	*For both Pharm & DME* 1. **Diabetes diagnosis required**	2. **For DME only: Multiple (3+) daily insulin injections or pump and not meeting glycemic targets**	3. For DME only: Have recurrent, unexplained, severe hypoglycemia (generally blood glucose levels <50 mg/dL) or impaired awareness of hypoglycemia that puts the patient or others at risk; **OR** 4. For DME only: Have poorly controlled insulin requiring diabetes who are pregnant. Poorly controlled insulin requiring diabetes includes unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis or are pregnant and have unexplained hypoglycemic episodes, hypoglyemic unawareness, postprandial hyperglycemia or recurrent diabetic ketoacidosis

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE: Commercial Plans (cont)

See an error in this document? Let us know: ccteam@mct2d.org

	Coverage: Pharm or DME?	1 Requirement: Diabetes Dx	2 Requirement: Insulin Rx	3 Requirements: Other & Notes
Commercial Plans				
HAP ***Commercial & MA plans***	**Pharm** Preferred Brand(s) **Dexcom, Abbott Freestyle Libre** *$0 copay if through Pharmacy Advantage or patient's pharmacy*	**1. Diabetes diagnosis required**	**2. Must be treated with insulin OR Treated with 3+ non-insulin products AND has uncontrolled HgBA1c**	Use PREFERRED VENDOR Pharmacy Advantage (800) 456-2112, M-F, 8 a.m. to 6 p.m. https:// www.pharmacyadvantagerx. com/ index.cfm
Priority *Traditional & Optimized*	**Pharm** Preferred Brand(s) **Abbott Freestyle Libre, Dexcom**	**1. Diabetes diagnosis required**	**2. Insulin Rx claim in last 6 months** Claims Autolookback	
United	**Pharm - For MCT2D members only** **For MCT2D members who are UHC in-network providers:** You can bypass criteria, only T2D diagnosis is required for patients with OptumRx. For MCT2D-members with any issues with the pharmacy benefit bypass for commercial patients, contact United using this form: https://michmed.org/zRwGW **DME** PA For non MCT2D members (see requirements to the right) Preferred Brand(s) **Abbott Freestyle Libre, Dexcom**	**1. Diabetes diagnosis required**		
			IF DME (non-MCT2D members): **2. 3x daily insulin injections or pump** **AND** Frequent adjustments to treatment regimen necessary based on glucose testing results	If DME: Assessed by a provider every six months for adherence to the prescribed CGM regimen and treatment plan. Documented compliance to physician-directed comprehensive diabetes management program. See Medical Policy (updated July 1, 2023) and InterQual criteria (provider log-in required) for more info.

MCT2D Medication & CGM Coverage - Preferred Drugs

Medicare Advantage Plans

For complete coverage information, see the full Medication and CGM Coverage Guide https://michmed.org/4QQ5g

Medicare Advantage Plan with formulary URL	GLP-1 RA	SGLT2-i	CGM Coverage & Criteria
Aetna (MA) michmed.org/8NQrk	Ozempic Rybelsus (Oral) Trulicity Victoza Bydureon Bcise	Farxiga Jardiance	Most MA plans require DME. Device must have standalone reader (not just smart phone app) to qualify for Medicare DME. Preferred Brand(s): Abbott Freestyle Libre 2* OR Dexcom G6, G7 **For all Medicare plans, must document the following: michmed.org/dJ8z3** 1. Diabetes diagnosis 2. The beneficiary (or the beneficiary's caregiver) has received appropriate training in the use of the device as evidenced by a prescription 3. The CGM is being prescribed in accordance with FDA indications for use 4. The CGM is being prescribed to improve glycemic control for a beneficiary who is **insulin treated** or has a **history of problematic hypoglycemia.** Definition as follows: **If NON insulin treated, must also have a history of hypoglycemia (defined as EITHER):** **Moderate (Level 2):** a. At LEAST two documented events in EMR (glucose <54mg/dL or "Level 2") and b. At LEAST two previous medication adjustments prior to the most recent Level 2 event ***or*** **Severe (Level 3):** a. At LEAST one documented event in EMR (glucose <54mg/dL or "Level 3") and b. Documentation in EMR that patient required 3rd party assistance for treatment. *As of 8/28/23, Freestyle Libre 3 (smartphone only, no reader) is not covered by the CMS Medicare policy. ***United MA*** are currently the only MA plans that allow CGM through Pharmacy benefit, while still being part of Medicare Part B coverage
BCBSM/BCN (MA) michmed.org/DymRY	Bydureon Bcise Ozempic Rybelsus Trulicity Victoza **Claims Hx: T2D Dx or med**	Farxiga Jardiance	
HAP (MA) Step Therapy (ST): michmed.org/2VPGZ	Mounjaro Ozempic Rybelsus (Oral) Trulicity Victoza **Claims Hx: Metformin Rx (<120 days)**	Farxiga Jardiance	
Humana (MA) michmed.org/kQ894	Mounjaro Ozempic Rybelsus (Oral) Trulicity Victoza	Invokana Jardiance	
Priority (MA) michmed.org/7NVGN	Bydureon Bcise Mounjaro Trulicity	Farxiga Jardiance	
United (MA) michmed.org/YkDR3	Bydureon Bcise Mounjaro Trulicity	Farxiga Jardiance	
Wellcare (MA) michmed.org/gRWDV	Bydureon Bcise Mounjaro Ozempic Rybelsus (Oral) Trulicity Victoza	Farxiga Jardiance	

MCT2D Medication & CGM Coverage - Preferred Drugs

Medicaid Plans

If plan includes a pharmacy carveout, check the pharmacy carveout company's coverage criteria. **For complete coverage information, see the full Medication and CGM Coverage Guide https://michmed.org/4QQ5g**

MEDICAID Plans with Formulary URL	**GLP-1 RA (Injectable)**	**SGLT2-i**	**CGM Coverage & Criteria**
Medicaid State Plan and managed plans (Aetna, HAP, McLaren, Meridian, Priority, United, Upper Peninsula) michmed.org/N2wn8	Byetta Trulicity Victoza	Farxiga (not HAP) Invokana Jardiance	Preferred Brand: Abbott Libre, Dexcom Benefit Type: DME Medicaid Criteria: 1.) The beneficiary is under the care of an endocrinologist, a physician, or a non-physician practitioner (nurse practitioner, physician assistant, or clinical nurse specialist) who is managing their type 2 diabetes. 2.) Has diabetes requiring the administering of insulin or pump. 3.) The beneficiary or their caregiver is educated on the use of the device and is willing and able to use the CGMS.
Blue Cross Complete *(BCBSM managed Medicaid)* michmed.org/xNX5W CGM Policy *effective 8/1/22:* michmed.org/PJGPA	Byetta Trulicity Victoza **Claims Hx: T2D Dx or med**	Farxiga (not HAP) Invokana Jardiance	Preferred Brand: Abbott Libre 14 Day, Abbott Libre 2, Abbott Libre 3, Dexcom G6, Dexcom G7 Benefit Type: Pharmacy 1. Diagnosis of diabetes AND Either **Criteria #1** or ***one* of the criteria under #2:** **Criteria 1:** Treatment with insulin (type 1 or type 2) OR **Criteria 2:** Treatment of Type 2 diabetes with an antihyperglycemic drug without insulin. *One of the following must be met:* a. Frequent hypoglycemia, hypoglycemia unawareness, or concerns of nocturnal hypoglycemia b. Gaining weight (more than 5 pounds of weight gain in the last 12 months) c. HbA1C ≥ 7% d. Need for medication changes or titration e. Initiation of a lower carbohydrate diet f. Patient is unable or reluctant to test their blood glucose via traditional glucometer. g. Patient is taking two or more medications to manage their diabetes. h. Patient works with a care team member to improve diet and exercise choices. **With treatment of Type 2 Diabetes and no insulin** * Documentation of positive clinical response (i.e. improved HbA1C or reduced frequency of severe hypoglycemia episodes)

MCT2D Medication & CGM Coverage - Preferred Drugs

Commercial Plans

If plan includes a pharmacy carveout, check the pharmacy carveout company's coverage criteria.
For complete coverage information, see the full Medication and CGM Coverage Guide https://michmed.org/4QQ5g

Commercial Plans with Formulary URL	**GLP-1 RA (Injectable)**	**SGLT2-i**	**CGM Coverage & Criteria** (Disclaimer: Pharmacy Carve-Outs may augment the benefit type and criteria)
Aetna *(Advanced Control)* michmed.org/97Ay9 CGM: michmed.org/3xAqb	Mounjaro Ozempic Rybelsus Trulicity Victoza	Farxiga Jardiance	Preferred Brand: Dexcom Benefit type: If using Pharmacy, only criteria is T2D diagnosis, and it is optional If using DME, criteria: 1. Type 1 or type 2 diabetes diagnosis 2. 3+ daily insulin injections or insulin pump therapy 3. a.) experiencing improved glycemic control or decreased hypoglycemia episodes while using a CGM b.) are being assessed every six months by the prescriber for adherence to their CGM regimen and diabetes treatment plan.
BlueCross BlueShield Michigan michmed.org/nmxVD CGM: michmed.org/w8nMW	Mounjaro Ozempic Rybelsus (Oral) Trulicity Victoza **Claims Hx: T2D Dx OR T2D Med**	Farxiga Jardiance	Preferred Brand(s): Abbott Libre OR Dexcom Benefit type: Pharmacy Criteria: T2D Diagnosis Benefit type: DME Criteria: 1. 3+ daily insulin injections or pump and not meeting glycemic targets 2. Have recurrent, unexplained, severe hypoglycemia (generally blood glucose levels <50 mg/dL) or impaired awareness of hypoglycemia that puts the patient or others at risk
ExpressScripts National michmed.org/Dyq2x	Bydureon Bcise Mounjaro Ozempic Rybelsus (Oral) Trulicity	Farxiga Jardiance Steglatro	Preferred Brand(s): Abbott Libre OR Dexcom
HAP michmed.org/qdV9P	Mounjaro Ozempic Rybelsus (Oral) Trulicity Victoza **Claims Hx: Metformin Rx (<120 days) michmed.org/2VPGZ**	Farxiga Jardiance	Preferred Brand(s): Abbott Libre OR Dexcom Pharmacy ONLY: Contact Pharmacy Advantage at 800-456-2112. 1. Diagnosis of Type 1 or 2 diabetes 2. Ability to use the system or access to a caregiver who has such abilities, and ONE of the following: 3. Must be treated with insulin OR treated with 3+ non-insulin
Priority *(Traditional)* michmed.org/yq299 CGM: michmed.org/dJzPq	Mounjaro Ozempic Trulicity Victoza **Claims Hx: T2D Dx**	Farxiga Jardiance	Preferred Brand(s): Abbott Libre OR Dexcom Benefit type: Pharmacy Criteria: T2D Diagnosis AND insulin RX claim in last 6 months
Priority *(Optimized)* michmed.org/BA4Kb CGM: michmed.org/dJzPq	Mounjaro Trulicity **PA criteria (PDF) michmed.org/jm85Q**	Farxiga Jardiance	

MCT2D Medication & CGM Coverage - Preferred Drugs

Commercial Plans

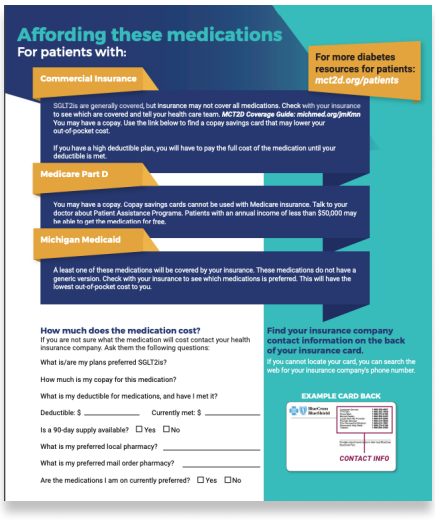
If plan includes a pharmacy carveout, check the pharmacy carveout company's coverage criteria.
For complete coverage information, see the full Medication and CGM Coverage Guide https://michmed.org/4QQ5g

Commercial Plans with Formulary URL	**GLP-1 RA** (Injectable)	**SGLT2-i**	**CGM Coverage & Criteria** (Disclaimer: Pharmacy Carve-Outs may augment the benefit type and criteria)
United michmed.org/7NJrY CGM: michmed.org/nmxYW	Bydureon BCise Mounjaro Ozempic Rybelsus (Oral) Trulicity Victoza **Step therapy 3 month metformin trial, C&I or suboptimal response** **michmed.org/vJmqe**	Jardiance *Farxiga* *Invokana* *Steglatro* **Jardiance: ST 3 month metformin trial, C&I or suboptimal response** **Others: Metformin & Jardiance trial** **CKD/HF/T2D michmed.org/Yk9Yb**	Preferred Brand(s): Abbott Libre OR Dexcom Benefit Type: Pharmacy Criteria for Coverage: **For MCT2D Members ONLY:** 1. Ordered by an MCT2D participating provider 2. Patient has T2D diagnosis Benefit Type: DME, For Non-MCT2D Members: 1. Diagnosis of diabetes requiring insulin 2. Blood glucose testing at least 4x daily 3. Insulin injections at least 3 x daily OR pump 4. Frequent adjustments to treatment regimen necessary based on glucose testing results 5. Documented compliance to physician-directed comprehensive diabetes management program 6. Assessed by a provider every six months

Additional MCT2D Resources for Patients

Affording your Type 2 Diabetes Care: A Patient Toolkit on Insurance Coverage and Cost

Includes the What to Ask Your Insurance Company worksheet, guides to Patient Assistance Programs and Copay Coupons
https://michmed.org/8Rq4d



The Benefits of New Diabetes Meds: Starting an SGLT2i or GLP-1 RA

Patients most common questions answered.
https://michmed.org/YkZ5w

Getting started with a CGM: Patient Guide

Links and information on additional support for getting started with an Abbott or Dexcom CGM
https://michmed.org/WA2W2

COVERAGE GUIDE APPENDIX

2023 FORMULARY, STEP THERAPY & PRIOR AUTHORIZATION, AND DME POLICY LINKS & PROVIDER PHONE LINES

PAYOR	2023 FORMULARY URL	ST/PA GUIDELINES URL	CGM DME POLICY URL	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
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	michmed.org/MMxnk	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	michmed.org/8NRev	See Medicare/CMS policy listed above	855-538-0454
Aetna	michmed.org/97Ay9	michmed.org/KqrMw Wegovy: michmed.org/QRQMm	michmed.org/3xAqb	PA 800-414-2386
BCBSM	michmed.org/nmxVD	michmed.org/zRQZB	michmed.org/w8nMW	800-344-8525
Express Scripts	michmed.org/Dyq2x	michmed.org/3xAey	n/a	888-327-9791
HAP	michmed.org/qdV9P	PA: michmed.org/vJV3A ST: michmed.org/2VPGZ	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

Definitions and Disclaimers

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