



Prior Authorization Guideline

Guideline Name	Diabetic GLP-1 Agonists (Weekly)
Formulary	Medicaid - CareOregon (CORMCAID)

Guideline Note:

Effective Date:	7/21/2026
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1 . Criteria

Product Name: Exenatide, Mounjaro, Trulicity, Ozempic	
Diagnosis	Diabetes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Type 2 Diabetes AND 2 - One of the following:	

2.1 Both of the following:

2.1.1 Patient has one of the following conditions:

- ASCVD
- Chronic kidney disease with eGFR 25-75 mL/min/1.73 m² and UACR greater than 100 mg/g

AND

2.1.2 One of the following:

2.1.2.1 Trial and failure, contraindication, or intolerance to an Sodium-glucose cotransporter 2 (SGLT2) inhibitor

OR

2.1.2.2 Both of the following:

- Patient will continue treatment with an SGLT2 inhibitor
- Patient has an HbA1c greater than 7%

OR

2.2 All of the following:

2.2.1 Trial and failure or contraindication to metformin

AND

2.2.2 Patient has an HbA1c greater than 7 percent (%)

AND

2.2.3 A minimum duration of a 3-month trial and failure, to TWO of the following therapies at maximum tolerated doses:

- sulfonylurea (e.g., glipizide, glimepiride)

- pioglitazone
- alogliptin*
- SGLT2 inhibitor (e.g., Stelagtro)

AND

3 - Trial and failure or contraindicated to liraglutide

AND

4 - Medication is not being co-administered with another GLP-1 receptor agonist or GIP (e.g., Mounjaro)

Notes	*Prior authorization is required
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Product Name: Exenatide, Mounjaro, Trulicity, Ozempic	
Diagnosis	Diabetes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - At least one HbA1c has been obtained in the previous 6 months*	
Notes	*If HbA1c is not provided, only approve for 2 months 1 time. Deny after first grace authorization provided due to lack of A1c

Product Name: Exenatide, Mounjaro, Trulicity, Ozempic	
Diagnosis	Diabetes with Obstructive Sleep Apnea (OSA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Type 2 Diabetes	

AND

2 - One of the following:

2.1 Trial of and will continue therapy with metformin

OR

2.2 Patient has a failure, contraindication or intolerance to metformin

AND

3 - Patient has a BMI of greater than 30 kg/m²

AND

4 - Diagnosis of moderate to severe obstructive sleep apnea as confirmed by polysomnography

AND

5 - One of the following:

5.1 Patient has fully maximized the use of positive airway pressure therapy

OR

5.2 Submission of medical records (e.g., chart notes) documenting an inability to tolerate positive airway pressure therapy

AND

6 - Patient has tried a weight loss treatment plan administered by a health care provider (e.g.,

diet and exercise program, nutrition counseling, or a calorie restricted diet) for at least a 3-month period within the past 6 months

AND

7 - Trial and failure or contraindication to liraglutide

Product Name: Exenatide, Mounjaro, Trulicity, Ozempic

Diagnosis	Diabetes with Obstructive Sleep Apnea (OSA)
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Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g., chart notes) documenting a reduction in sleep-related impairment

AND

1.2 Patient is continuing treatment with positive airway pressure therapy

OR

2 - At least one HbA1c has been obtained in the previous 6 months*

Notes	*If HbA1c is not provided, only approve for 2 months 1 time. Deny after first grace authorization provided due to lack of A1c
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