

CUSTOM PRIOR AUTHORIZATION GUIDELINES

LIXISENATIDE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
LIXISENATIDE	ADLYXIN			GPI-10	
				(2717005600)	

GUIDELINES FOR USE

CRITERIA

1. Does the patient have a documented diagnosis of Type 2 Diabetes Mellitus?

If yes, approve the requested drug for 12 months by GPID or GPI-14.

If no, do not approve.

DENIAL TEXT: See the denial text at the end of the guideline.

DENIAL TEXT:

Our guideline named **LIXISENATIDE** (**Adlyxin**) requires that you have a documented diagnosis of Type 2 Diabetes Mellitus.

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Adlyxin.

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