Drug Coverage Policy

Effective Date……04/01/2026
Coverage Policy Number……IP0701
Policy Title…..Diabetes - Glucagon-Like Peptide-1 Agonists for Employer Plans

Diabetes – Glucagon-Like Peptide-1 Agonists for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists

- Bydureon BCise® (exenatide extended-release subcutaneous injection – AstraZeneca [obsolete 03/31/2025])
- Byetta® (exenatide subcutaneous injection – AstraZeneca, [brand obsolete 03/06/2025] generic)
- Mounjaro® (tirzepatide subcutaneous injection – Eli Lilly)
- Ozempic® (semaglutide subcutaneous injection – Novo Nordisk)
- Rybelsus® (semaglutide tablets – Novo Nordisk)
- Trulicity® (dulaglutide subcutaneous injection – Eli Lilly)
- Victoza® (liraglutide subcutaneous injection – Novo Nordisk, generic)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where

coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview
The glucagon-like peptide-1 (GLP-1) receptor agonists and the GLP-1/glucose-dependent insulinotropic polypeptide-1 (GIP) agonist addressed in this policy are indicated as adjuncts to diet and exercise to improve glycemic control in adults with **type 2 diabetes**.[1-7] Liraglutide, Mounjaro, Trulicity, and Bydureon BCise are additionally indicated for type 2 diabetes in patients ≥ 10 years of age.[1,2,6,7] Liraglutide, Ozempic, Rybelsus, and Trulicity also have labeled indications related to cardiovascular (CV) risk reduction in adults with type 2 diabetes.[4-7] Additionally, Ozempic is indicated to reduce the risk of sustained estimated glomerular filtration decline, end-stage kidney disease, and CV death in adults with type 2 diabetes and chronic kidney disease.[4]

Guidelines
According to the American Diabetes Association Standards of Care (2026), pharmacologic therapy be guided by person-centric treatment factors including comorbid conditions, as well as treatment goals, and preferences.[8] Pharmacotherapy should be initiated at the time type 2 diabetes is diagnosed unless there are contraindications.

American Association of Clinical Endocrinologists statement on the comprehensive care for type 2 diabetes (2023) provides principles for the management of type 2 diabetes.[9] Similar to the ADA standards of care, the choice of antihyperglycemic therapy should reflect glycemic targets as well as underlying conditions.

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POLICY STATEMENT
Prior Authorization is required for benefit coverage of the GLP-1 agonists and GLP-1/GIP agonist targeted in this policy. Of note, Saxenda® (liraglutide subcutaneous injection), Wegovy® (semaglutide tablet and subcutaneous injection), and Zepbound® (tirzepatide subcutaneous injection) are not indicated for the treatment of diabetes and are not targeted in this policy. All approvals are provided for the duration noted below.

Documentation: Documentation is required for use of GLP1 Products as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory results, claims records, and/or other information.

I. Byetta, and Victoza are considered medically necessary when the following is met:

FDA-Approved Indication

1. **Type 2 Diabetes Mellitus.** Approve for 1 year if the patient meets **ALL** of the following (A and B):
   A) Diagnosis of Type 2 diabetes mellitus **[Documentation Required]**
   B) Preferred product criteria is met for the product(s) as listed in the below table(s)

II. Bydureon BCise, exenatide subcutaneous injection, liraglutide subcutaneous injection (generic to Victoza), Mounjaro, Ozempic, Rybelsus and Trulicity are considered medically necessary when the following is met:

FDA-Approved Indication

1. **Type 2 Diabetes Mellitus.** Approve for 1 year if the patient meets the following:
   A) Diagnosis of Type 2 diabetes mellitus **[Documentation Required]**

Employer Plans:

Product	Criteria
Byetta (exenatide) subcutaneous injection	The patient has tried **exenatide subcutaneous injection** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) [for example, difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.
Victoza (liraglutide) subcutaneous injection	**ONE** of the following (1 or 2): 1. Patient is 18 years of age of older AND has tried BOTH of the following (A and B): A. Ozempic (semaglutide) B. Trulicity (dulaglutide) 2. Patient is less than 18 years of age AND has tried Trulicity (dulaglutide)

Conditions Not Covered

Glucagon-Like Peptide-1 Agonists for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Weight Loss Treatment**. Saxenda (liraglutide subcutaneous injection) contains the same chemical entity as liraglutide (Victoza, generic) and is indicated at a higher dose for chronic weight management. Wegovy (semaglutide tablet and subcutaneous injection) contains the same chemical entity as Ozempic and is indicated at a higher dose for chronic weight management. Zepbound (tirzepatide subcutaneous injection) contains the same chemical entity as Mounjaro and is indicated at the same doses for chronic weight management. The GLP-1 agonists and GLP-1/glucose-dependent insulinotropic polypeptide-1 agonist in this policy are not FDA-approved for weight loss in a patient who is overweight (body mass index [BMI] ≥ 27 kg/m^2) or obese (BMI ≥ 30 kg/m^2) without type 2 diabetes.
   Note: If the patient has type 2 diabetes, refer to FDA-Approved Indication.

2. **Type 1 Diabetes Mellitus.** None of the GLP-1 agonists or GLP-1/ glucose-dependent insulinotropic polypeptide-1 agonist are indicated for patients with type 1 diabetes.[1-7]

Addition of GLP-1 receptor agonists to insulin therapy resulted in small (0.2%) reductions in hemoglobin A_{1c} among patients with type 1 diabetes compared with insulin alone.[8]

3. **Prediabetes/Diabetes Prevention.** GLP-1 agonists and the GLP-1/ glucose-dependent insulinotropic polypeptide-1 agonist are not indicated in a patient with elevated blood glucose who does not have type 2 diabetes. The American Diabetes Association Standards of Care (2026) recommend consideration of metformin for the prevention of type 2 diabetes in adults at high-risk of type 2 diabetes, and in individuals with prior gestational diabetes mellitus. First-line recommendations to prevent or delay type 2 diabetes are lifestyle and behavioral modification (e.g., nutrition, physical activity, sleep).[8] Further, metformin has the longest history of safety data as a pharmacologic therapy for diabetes prevention.
   Note: If the patient has type 2 diabetes, refer to FDA-Approved Indication.

4. **Metabolic Syndrome.** The GLP-1 agonists and the GLP-1/glucose-dependent insulinotropic polypeptide-1 agonist are not indicated in a patient with metabolic syndrome who does not have type 2 diabetes.
   Note: If the patient has type 2 diabetes, refer to FDA-Approved Indication.

5. **Concomitant Use with Glucagon-Like Peptide-1 (GLP-1) Agonists or GLP-1/ Glucose-Dependent Insulinotropic Polypeptide (GIP) Agonist.** The GLP-1 agonists and the GLP-1/GIP agonist should not be combined with each other or with any other GLP-1 agonists or GLP-1/GIP agonist. There are other GLP-1 and GLP-1/GIP products not included in this policy that are FDA-approved for weight loss and are not indicated for type 2 diabetes.
   Note: Examples of other GLP-1 agonists not included in this policy include but are not limited to Saxenda (liraglutide subcutaneous injection) and Wegovy (semaglutide tablet and subcutaneous injection). An example of a GLP-1/GIP agonist not included in this policy is Zepbound (tirzepatide subcutaneous injection).

References

1. Mounjaro® subcutaneous injection [prescribing information]. Indianapolis, IN: Lilly; December 2025.
2. Bydureon BCise® subcutaneous injection [prescribing information]. Wilmington, DE: AstraZeneca; May 2025.
3. Byetta® subcutaneous injection [prescribing information]. Wilmington, DE: AstraZeneca; May 2025.
4. Ozempic® subcutaneous injection [prescribing information]. Plainsboro, NJ: Novo Nordisk; January 2025.
5. Rybelsus® tablets [prescribing information]. Plainsboro, NJ: Novo Nordisk; October 2025.
6. Trulicity® subcutaneous injection [prescribing information]. Indianapolis, IN: Lilly; May 2025.
7. Victoza® subcutaneous injection [prescribing information]. Plainsboro, NJ: Novo Nordisk; May 2025.
8. American Diabetes Association. Standards of care in diabetes – 2026. *Diabetes Care*. 2026;49(Suppl 1):S1-S371.
9. Samson SL, Vellanki P, Blonde L, et al. American Association of Clinical Endocrinology consensus statement: comprehensive type 2 diabetes management algorithm – 2023 update. *Endocr Pract.* 2023;29:305-340.

Revision Details

Summary of Changes	Review Date	Effective Date
New policy	9/19/2024	10/15/2024
Added generic exenatide to the policy to follow Byetta criteria **Preferred Product Table:** **Updated** Adlyxin alternative **from** "Bydureon BCise OR Byetta" **to** "Bydureon BCise OR Byetta OR exenatide subcutaneous injection"	5/1/2025	06/01/2025
Conditions Not Covered **Prediabetes/Diabetes Prevention.** **Updated** the statement with information from the 2025 American Diabetes Association Standards of Care.	6/12/2025	08/15/2025
Preferred Product Table: **Added** preferred product requirements for Byetta. **Removed** preferred product requirements for Liragultide subcutaneous injection (generic for Victoza).	7/10/2025	09/01/2025
Adlyxin was removed from the policy (obsolete). **Conditions Not Covered.** Updated the Weight Loss Treatment statement.	1/29/2026	04/01/2026

The policy effective date is in force until updated or retired.