



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Mounjaro (tirzepatide)

Page: 1 of 2

Effective Date: 7/1/2024

Last Review Date: 6/10/2024

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> New Jersey
	<input checked="" type="checkbox"/> Maryland	<input checked="" type="checkbox"/> Florida Kids	<input checked="" type="checkbox"/> Pennsylvania Kids
	<input type="checkbox"/> Michigan	<input type="checkbox"/> Virginia	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Mounjaro under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Mounjaro is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- Mounjaro has not been studied in patients with a history of pancreatitis.
- Mounjaro is not indicated for use in patients with type 1 diabetes mellitus.

Applicable Drug List:

Mounjaro

Policy/Guideline:

Criteria for Approval:

- I. The requested drug will be covered with prior authorization when the following criteria are met:**
 - The patient has a diagnosis of type 2 diabetes mellitus
 - AND**
 - The patient had a trial and inadequate treatment response, intolerance, or a contraindication to the preferred agents, Ozempic and Trulicity, (Documentation is required for approval).
 - AND**
 - The patient has NOT been receiving a stable maintenance dose of the requested drug for at least 3 months **AND**
 - The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to metformin
 - OR**
 - The patient requires combination therapy AND has an A1C of 7.5 percent or greater
- OR**
- The patient has been receiving a stable maintenance dose of the requested drug for at least 3 months **AND**
 - The patient has demonstrated a reduction in A1C since starting this therapy



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Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit: 4 single dose pens (2mL) or single-dose vials (2mL) per 28 days

References:

1. Mounjaro [package insert]. Indianapolis, IN: Lilly USA, LLC; July 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2023. <https://online.lexi.com>. Accessed July 26, 2023.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 07/26/2023).
4. El Sayed NA, Aleppo G, Aroda VR et. al. American Diabetes Association, Standards of Care in Diabetes – 2023. *Diabetes Care* 2023;46(Suppl. 1):S1-S291.
5. Blonde L, Umpierrez GE, Reddy SS et. al. American Association of Clinical Endocrinology Clinical Practice Guideline: Developing a Diabetes Mellitus Comprehensive Care Plan – 2022 Update. *Endocrine Practice* 2022; 28(10) 923-1049.
6. Davies MJ, Aroda VR, Collins BS, et. al. Management of Hyperglycemia in Type 2 Diabetes, 2022. A Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetes Care* 2022;45(11):2753-2786.