What's New in this Guide

Last updated 14 March 2023
v2023.1.2

Change Log

Payer	Drug/Device	Change
BCBSM	**Mounjaro** (tirzepatide)	Changed from "No Info" to Non Preferred, PA="For the treatment of Type 2 Diabetes or trial of one generic or preferred medication for the treatment of Type 2 Diabetes"
Priority Health Optimized	**Mounjaro** (tirzepatide)	Changed from "No Info" to Preferred Tier 2 (brand) with prior authorization. Please review the plan's PA criteria, as it is more stringent than Priority Health Traditional commercial plan.
HAP	**Mounjaro** (tirzepatide)	Mounjaro is now covered
United	**Mounjaro** (tirzepatide)	Mounjaro is now covered, with PA/ST trial of, or CI metformin
United	**Farxiga** (dapagliflozin) **Invokana** (canagliflozin)	Changed from "Non Preferred with ST " to "May be excluded from coverage or subject to PA in CT, NJ and NY."
All	**Adlyxin** (Lixisenatide)	Adlyxin is no longer covered in the United States
Aetna & Express Scripts	**Phentermine**	Phentermine is no longer covered
HAP	**Qsymia** (Phentermine - Topiramate)	Changed from "Not Covered" to Not Preferred ($$$$) with PA

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Last updated 14 March 2023
v2023.1.2

Change Log

Payer	Drug/Device	Change
United	**Jardiance** (Empagliflozin)	Removed metformin step therapy requirement. As of Oct 10, 2022.
BCBSM Medicare Advantage	**Jardiance** (Empagliflozin)	FIXED: Jardiance is Preferred (Tier 3 - lowest branded copay). As of Oct 1, 2022.
BCBSM Commercial	**Victoza** (Liraglutide)	FIXED: Victoza is Preferred Brand.
Medicare	**CGMs**	Updated DME criteria to align with March 3, 2023 CMS policy update - including removal 3x daily insulin and In-person appointment 6 months before/after CGM RX and addition of hypoglycemic event and updated insulin criteria, in-person or Medicare-approved virtual visits, and additional documentation criteria. **Effective April 16, 2023**.
Medicaid	**CGMs**	Removed "unknown designation" and updated with **proposed May 1, 2023** policy 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.) Provider must document that beneficiary completed a DSME training within 1 year of CGM order 3.) The beneficiary is prescribed and uses insulin or an insulin pump 4.) The beneficiary tests blood glucose 2x or more per day 5.) The beneficiary is educated on the use of the device and willing and able to use CGMs

PRIVATE & PBM Coverage for GLP-1 RA & GIP

USE CO-PAY COUPON

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	Preferred PA	Preferred PA	Preferred PA	Preferred PA	No Info	Not Covered
BCBSM	Preferred	Preferred	Preferred	Preferred	PA **Non Preferred** T2D OR trial of generic or preferred med for T2D	Not Covered
EXPRESS SCRIPTS National Preferred	Preferred	Preferred	Preferred	Not Covered	Preferred	Preferred
HAP	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Preferred ST Trial or CI Metformin	Not Covered
PRIORITY	Preferred	Preferred Must have T2D diagnosis code	Not Covered	Preferred	Preferred PA If T2D ICD-9 code is not on file	Non Preferred ST Must first try Trulicity, Bydureon, or Byetta
PRIORITY (OPTIMIZED)	Preferred PA See PA criteria below	$$$$$$ PA ST Criteria as of Feb '22: michmed.org/3A2Av	Not Covered	$$$$$$ PA ST Criteria as of Feb '22: michmed.org/3A2Av	Preferred PA See PA criteria below	$$$$$$ 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

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

PA **Prior Auth**

ST **Step Therapy**

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

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, in 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%

PRIVATE & PBM
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 ST	Preferred ST	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

Information based on general formularies, unless otherwise noted (i.e. Priority Optimized plan, ExpressScripts PBM) and may not reflect employer-group specific policies and plans with pharmacy carve outs.

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	No Info	Preferred
BCBSM/BCN MA	Preferred	Preferred	Preferred	Preferred	No Info	Preferred
HAP MA	Preferred ST	Preferred ST	Preferred ST	Preferred ST	No Info	Not Covered
HUMANA MA	Preferred	Preferred	Preferred	Preferred	Preferred	$$$$$$ Not Preferred
PRIORITY MA	Preferred	$$$$$$ Non Preferred ST	Not Covered	$$$$$$ Non Preferred ST	Preferred	Preferred
UNITED EGWP	Preferred	Preferred	Preferred	Preferred	No Info	Preferred
WELLCARE MA	Preferred	Preferred	Preferred	Preferred	No Info	Preferred

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

Note on BCBSM/BCN MA: Individually purchased Prescription Blue PDP does not cover Trulicity. All other BCBS MA plans do, including Group Prescription Blue PDP.

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

	JARDIANCE Empagliflozin *Oral - Daily*	FARXIGA Dapagliflozin *Oral - Daily*	INVOKANA Canagliflozin *Oral - Daily*	STEGLATRO Ertugliflozin *Oral - Daily*
AETNA MA	Preferred	Preferred	Not Covered	Not Covered
BCBSM/BCN MA	Preferred	Preferred	Not Covered	Not Covered
HAP MA	Preferred	Preferred	Not Covered	Not Covered
HUMANA MA	Preferred	$$$$$$ Non-Preferred	Preferred	Not Covered
PRIORITY MA	Preferred	Preferred	Non Preferred ST Must first try Farxiga, Xigduo, Jardiance or Synjardy	Non Preferred ST Must first try Farxiga, Xigduo, Jardiance or Synjardy
UNITED EGWP	Preferred	Preferred	Not Covered	Not Covered
WELLCARE MA	Preferred	Preferred	$$$$$$ Non Preferred	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

MEDICAID COVERAGE for GLP-1 RA & GIP

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 - 2X a day / Weekly*
MEDICAID State	**Preferred**	$$$$$$ **Non-Preferred** **PA** michmed.org/2VP94	$$$$$$ **Non-Preferred** **PA** michmed.org/2VP94	**Preferred**	**Not Covered**	$$$$$$ **Non Preferred** **PA**
AETNA **BCBSM** **HAP** **MCCLAREN** **MERIDIAN** **MOLINA** **PRIORITY** **UNITED** Managed	**Preferred**	**Not Covered** *Except Aetna* *Non-preferred* *PA*	**Not Covered** *Except Aetna* *Non-preferred* *PA*	**Preferred**	**No Info** *Except Aetna, BCBSM, United* *Not Covered*	**Not Covered** *(Byetta)* **Not Covered** *except for Aetna* *Non Preferred* *(Bydureon BCise)*

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

MEDICAID COVERAGE for SGLT2i

Recommended

	JARDIANCE Empagliflozin *Oral - Daily*	FARXIGA Dapagliflozin *Oral - Daily*	INVOKANA Canagliflozin *Oral - Daily*	STEGLATRO Ertugliflozin *Oral - Daily*
MEDICAID State	**Preferred**	**Preferred**	**Preferred**	$$$$$$ **Non-Preferred** **PA**
AETNA **BCBSM** **HAP** **MCCLAREN** **MERIDIAN** **MOLINA** **PRIORITY** **UNITED** Managed	**Preferred**	**Preferred** *Except HAP* *Not Covered - PA*	**Preferred**	**Not Covered** *Except Aetna* *Non-preferred* *PA*

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

PRIVATE & PBM 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	Not Covered	Not Covered	Preferred	Not Covered
BCBSM	$$$$$$ Non-Preferred PA	Preferred PA	Preferred	$$$$$$ Non-Preferred	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA
EXPRESS SCRIPTS National Preferred	$$$$$$ Non-Preferred PA	Preferred PA	Not Covered	Preferred	$$$$$$ Non-Preferred PA	$$$$$$ Non-Preferred PA
HAP	Not Covered	Not Covered	Preferred	Not Covered	$$$$$$ Non-Preferred PA	Not Covered
PRIORITY	Not Covered	Not Covered	Preferred	$$$$$$ Non-Preferred ST Must try generic first	$$$$$$ Non-Preferred** ST Must try generic first	$$$$$$ Non-Preferred ST Must try generic first
PRIORITY (OPTIMIZED)	Not Covered	Not Covered	Preferred	Not Covered	$$$$$$ Non-Preferred ST Must try generic first	$$$$$$ 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

No plans (at this time) offer coverage for: phentermine (any formulation), Qsymia, Contrave, Saxenda, or Wegovy

MEDICAID
Coverage for Anti-Obesity Meds

	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*	SAXENDA Liraglutide *Injectable - Daily*	WEGOVY Semaglutide *Injectable - Weekly*
MEDICAID State	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*
AETNA **BCBSM** **HAP** **MCCLAREN** **MERIDIAN** **MOLINA** **PRIORITY** **UNITED** Managed	Preferred *Except Priority Not Covered* PA *Age Criteria*	Preferred *Except McClaren Not Covered* PA	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*	Preferred PA *Age Criteria*

PA **Prior Auth**

ST **Step Therapy**

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

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE

	COVERAGE		CRITERIA - DOCUMENT IN CHART NOTE				
	PHARMACY	MEDICAL/DME	Needs T2D Diagnosis	Insulin	Hypoglycemic events	Seen for diabetes management in past 6 months	Additional criteria and notes
Medicare & Medicare Advantage	**NONE**	Preferred Brand(s) **Abbott Dexcom** Policy Link: michmed.org/dJ8z3 ***Updated March 3, 2023. Effective April 16, 2023.***	**Required** ***For DME***	*Must be EITHER:* *1.) "Insulin treated"* *OR* *2.) Have a history of problematic hypoglycemia* ***For DME***	If not insulin treated: EITHER 1.) AT LEAST TWO Level 2 hypoglycemic events (glucose <54mg/dL), with at least two previous medication adjustments and/or modifications to the treatment plan prior to the most recent Level 2 event (glucose <54mg/dL) OR 2.) AT LEAST ONE Level 3 hypoglycemic event (glucose <54mg/dL associated with altered mental and/or physical state), with documentation in the medical record that the patient required third party assistance for treatment. ***For DME***	**YES** In-person or Medicare approved virtual visit ***For DME***	Clinician must also document: 1.) The beneficiary (or the beneficiary's caregiver) has received appropriate training in the use of the device as evidenced by a prescription. 2.) The CGM is being prescribed in accordance with FDA indications for use. Device must have standalone reader (not just smartphone app) to qualify for DME MCT2D members recommend Parachute Health, ePrescribing platform.
Medicaid	**NONE**	***Currently under review for an effective date May 1, 2023.*** Preferred Brand(s) **Abbott Dexcom** Proposed medical policy: michmed.org/r84Vk ***Prior Authorization Required***	**Required** ***For DME***	**Required** *Prescribed and using insulin or pump* *AND* *2X daily readings* ***For DME***	**Not Required**	**YES** Must be 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. ***For DME***	Must also: 1.) Complete DSME training within 1 year of CGM order 2.) Be educated on the use of the device and willing and able to use CGMs Documentation must be less than 90 days old. Initial order must be written for 6 months.

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE

	COVERAGE		CRITERIA - DOCUMENT IN CHART NOTE				
	PHARMACY	MEDICAL/DME	Needs T2D Diagnosis	Insulin	Hypoglycemic events	Seen for diabetes management in past 6 months	Additional criteria and notes
Blue Cross Complete (BCBSM managed Medicaid)	Preferred Brand(s) **Abbott Dexcom** Policy Link: michmed.org/PJGPA		**Required** ***For Pharmacy***	**Required** *OR* Treatment with an antihyperglycemic drug without insulin ***AND one criteria on right*** ***For Pharm***	**Requied,** ***ONLY IF not on insulin*** Frequent hypoglycemia, hypoglycemia unawareness, or concerns of nocturnal hypoglycemia ***OR ONE of the criteria listed (see right)*** ***For Pharm***	**Not Required**	***IF NOT on insulin, NOT experiencing hypoglycemia,*** must meet one (1): a.) Gaining weight (more than 5 pounds of weight gain in the last 12 months) b.) HbA1C ≥ 7% c.) Need for medication changes or titration d.) Initiation of a lower carbohydrate diet e.) Patient is unable or reluctant to test their blood glucose via traditional glucometer f.) Patients taking two or more medications to manage their diabetes. g.) Patient works with a care team member to improve diet and exercise choices

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE

	COVERAGE		CRITERIA - DOCUMENT IN CHART NOTE				
	PHARMACY	MEDICAL/DME	Needs T2D Diagnosis	Insulin	Hypoglycemic events	Seen for diabetes management in past 6 months	Additional criteria and notes
Aetna	**NONE**	Preferred Brand(s) **Dexcom** Policy Link: https://michmed.org/3xAqb	**Required** ***For DME***	**Required** *Needs 3+ daily insulin injections or pump* ***For DME***	**Required** Including hypoglycemic unawareness OR not meeting glycemic targets ***For DME***	**Not Required** But may be required for continued use (see right) ***For DME***	***For continued use, must document EITHER*** 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. ***For DME***
BCBSM *Consult Individual Plans*	Preferred Brand(s) **Dexcom** *receiver & transmitter at $0 cost share* **Abbott** ***Have a pharmacy carveout? Refer to your carve out plan company's coverage criteria.***	**See DME Criteria (right)**	**Required** ***Applies to both Pharm & DME criteria***	**Required** *Needs 3+ daily insulin injections or pump and not meeting glycemic targets* ***DME criteria only***	**Required** *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* ***DME criteria only***	**UNKNOWN**	**For pregnant patients:** *Have poorly controlled insulin requiring diabetes, includes unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis.* ***DME criteria only***
HAP *Commercial and Medicare Advantage plans*	Preferred Brand(s) **Dexcom** **Abbott Freestyle Libre** *$0 copay if through Pharmacy Advantage or patient's pharmacy*	**NONE**	**Required** ***For Pharm***	**Required** *Must be treated with insulin OR Treated with 3+ non-insulin products AND has uncontrolled HgBA1c* ***For Pharm***	**Not Required**	**Not Required**	**Use PREFERRED VENDOR** *Pharmacy Advantage* *(800) 456-2112,* *M-F, 8 a.m. to 6 p.m.* *https://www.pharmacyadvantagerx.com/index.cfm*
McLaren	Preferred Brand(s) **Dexcom** PA		**UNKNOWN**	**UNKNOWN**	**UNKNOWN**	**UNKNOWN**	

CONTINUOUS GLUCOSE MONITORS (CGM) COVERAGE

	COVERAGE		CRITERIA - DOCUMENT IN CHART NOTE				
	PHARMACY	MEDICAL/DME	Needs T2D Diagnosis	Insulin	Hypoglycemic events	Seen for diabetes management in past 6 months	Additional criteria and notes
Molina	Preferred Brand(s) **Abbott Dexcom**	Preferred Brand(s) **Abbott Dexcom** Policy Link: https://michmed.org/gRWVY PA	**Required** *OR Documentation member is pregnant receiving insulin therapy* ***Pharm and DME***	**1.) ONE of the following (a-g) PLUS Additional criteria (2-3)** *a.) Compliant with 3x injections or pump* *b.) HbA1c above 7% and 4x daily readings* ***Pharm and DME***	*c.) Persistent, recurrent unexplained severe hypoglycemic events* *d.) Hypoglycemia unawareness* *e.) Episodes of ketoacidosis* *f.) Hospitalizations for uncontrolled glucose levels* *g.) Frequent nocturnal hypoglycemia despite appropriate modifications in insulin therapy*	**Not Required**	2.) Prescriber attests to scheduled or historical (last 12 mon) completion of training and support for CGM **AND** member/caregiver has 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. 3.) Prescriber attests member/caregiver has been counseled on potential drugs/substances that can falsely raise or lower CGM glucose levels such as APAP, ASA, vitamin C etc.
Priority *Traditional & Optimized*	Preferred Brand(s) **Dexcom Abbott**	**UNKNOWN**	**Required** ***For Pharm***	**Not Required**	**Not Required**	**Not Required**	
United	***MCT2D members*** who are UHC in-network providers **CAN BYPASS CRITERIA.** Only T2D diagnosis required Preferred Brand(s) **Abbott Dexcom** *(Tier 3 - Highest Cost)* PA	Preferred Brand(s) **Abbott Dexcom** Policy Link: https://michmed.org/nmxYW PA	**Required** **AND** **4x daily testing*** **For non-MCT2D member* ***Pharm and DME*** *s*	**Required*** *3x daily injections or pump* **AND** *Frequent adjustments to treatment regimen necessary based on glucose testing results* ***Pharm and DME***	**Not Required**	*Assessed by a provider every six months for adherence to the prescribed CGM regimen and treatment plan* ***Pharm and DME***	**ALSO REQUIRED** *Documented compliance to physician-directed comprehensive diabetes management program.* *See Medical Policy for more info.*

COVERAGE GUIDE APPENDIX

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

PAYOR	2023 FORMULARY URL	ST/PA GUIDELINES URL	DME POLICY URL	PROVIDE ASSISTANCE PHONE
Medicare	See MA plans	See MA plans	michmed.org/dJ8z3	800-633-4227
Medicaid	michmed.org/N2wn8	michmed.org/2VP94	michmed.org/r84Vk	800-292-2550
Blue Cross Complete	michmed.org/xNX5W	michmed.org/PJGPA	michmed.org/xNX5W	See region specific #
Molina	michmed.org/vJ4rz	n/a	michmed.org/gRWVY	855-326-5059
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	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
McLaren	michmed.org/QRr9A	n/a	n/a	888-327-0671
Priority *Traditional*	michmed.org/yq299	michmed.org/jm85Q	n/a	800-942-4765
Priority *Opimized*	michmed.org/BA4Kb	michmed.org/jm85Q	n/a	800-942-4765
United	michmed.org/7NJrY	michmed.org/Yk9Yb ST Mounjaro: michmed.org/gR89j	michmed.org/nmxYW	800-711-4555