



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Mounjaro (tirzepatide) Page: 1 of 3

Effective Date: 2/3//2025 Last Review Date: 12/2024

Applies to: Illinois Florida New Jersey
 Maryland Florida Kids Pennsylvania Kids
 Michigan 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:

Coverage Criteria

Type 2 Diabetes Mellitus

Authorization may be granted for a diagnosis of type 2 diabetes mellitus when ALL of the following criteria are met:

- The patient had a trial and inadequate treatment response, intolerance, or a contraindication to the preferred agents, Ozempic and liraglutide, (Documentation is required for approval).
- The patient meets ONE of the following:
 - The patient has a history of an A1C greater than or equal to 6.5 percent. [ACTION REQUIRED: Documentation is required for approval.]
 - The patient has a history of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT). [ACTION REQUIRED: Documentation is required for approval.]
 - The patient has a history of symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dL. [ACTION REQUIRED: Documentation is required for approval.]
 - The patient has a history of a fasting plasma glucose (FPG) greater than or equal to 126 mg/dL [ACTION REQUIRED: Documentation is required for approval.] when the following criteria is met:



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Mounjaro (tirzepatide) Page: 2 of 3

Effective Date: 2/3//2025 Last Review Date: 12/2024

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	

- The patient fasted for at least 8 hours prior to the fasting plasma glucose (FPG) greater than or equal to 126 mg/dL
- The patient has NOT been receiving a stable maintenance dose of the requested drug for at least 3 months and ONE of the following criteria are met:
 - The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to metformin
 - The patient requires combination therapy AND has an A1C of 7.5 percent or greater

Continuation of Therapy

Type 2 Diabetes Mellitus

Authorization may be granted for a diagnosis of type 2 diabetes mellitus when ALL of the following criteria are met:

- The patient meets ONE of the following:
 - The patient has a history of an A1C greater than or equal to 6.5 percent. [ACTION REQUIRED: Documentation is required for approval.]
 - The patient has a history of a 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test (OGTT). [ACTION REQUIRED: Documentation is required for approval.]

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.; 2024. <https://online.lexi.com>. Accessed March 11, 2024.
3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 03/11/2024).
4. 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. *Endocr Pract.* 2022;28(10):923-1049.
5. 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.
6. American Diabetes Association Professional Practice Committee. American Diabetes Association, Standards of Care in Diabetes – 2024. *Diabetes Care.* 2024;47(Suppl. 1):S1-S322.



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Mounjaro (tirzepatide)	Page:	3 of 3
Effective Date:	2/3//2025	Last Review Date:	12/2024
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	

7. Samson SL, Vellank 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.