Glucagon-like Peptide-1 (GLP-1) Receptor Agonist (GLP-1 RA)

Adjudication Guideline

Rule Category: Pharmaceutical	**Ref: No:** 2021-PH-09	**Version Control:** Version No. V5	**Effective Date:** 15/01/2023	**Revision Date:** 19/04/2026
Approved by: Daman	**Responsible:** Pharmaceutical Standards & Governance	**Related Adjudication Guidelines:** Obesity and Morbid obesity management		

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1. Abstract

1.1 For Members

Glucagon-like peptide-1 (GLP-1) receptor agonists (GLP-1 RAs) are medications used in the management of type 2 diabetes mellitus and obesity. They work by mimicking the effects of the naturally occurring incretin hormone GLP-1, which helps regulate blood sugar levels, appetite, and digestion.

1.2 For Medical Professionals

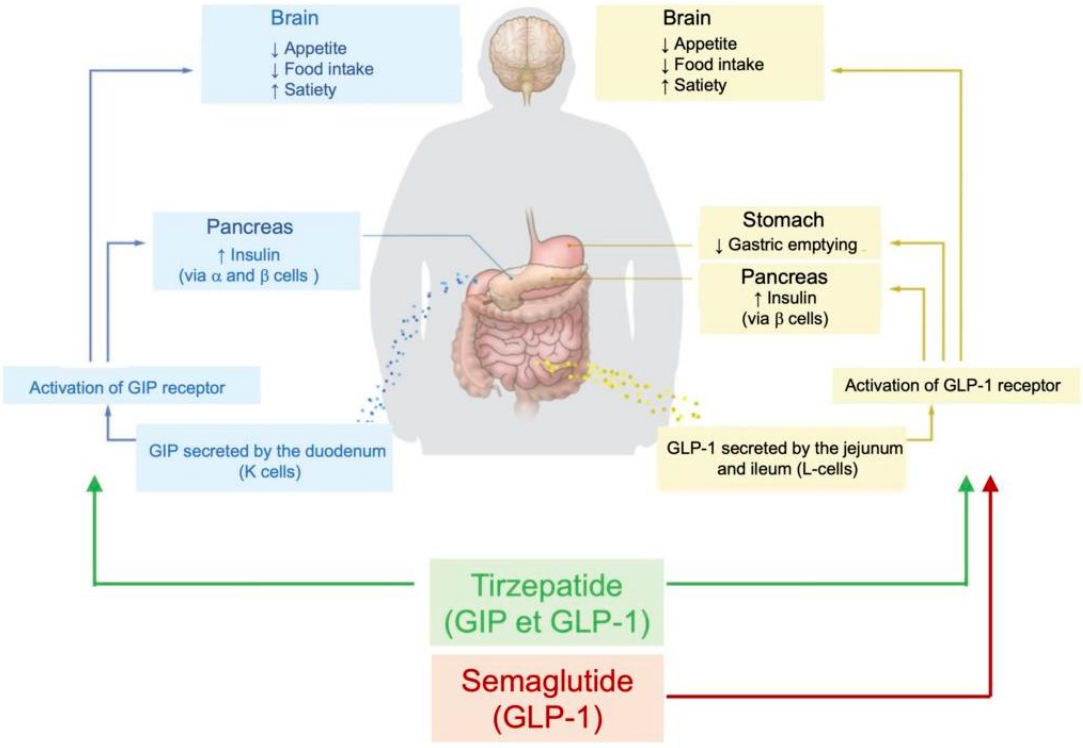
GLP-1 RA therapy is indicated for adults with type 2 diabetes who have established ASCVD, established CKD with cardiovascular disease, or multiple cardiovascular risk factors, and should be used with agents proven to provide cardiovascular benefit as part of comprehensive cardiovascular-risk reduction or glucose-lowering therapy, and is also indicated for obesity management.

Mechanism of Action

GLP-1 RAs exert their effects solely through activation of the glucagon-like peptide-1 (GLP-1) receptor, leading to glucose-dependent insulin secretion, suppression of glucagon release, delayed gastric emptying, and reduced appetite. Collectively, these effects contribute to improved glycaemic control and weight reduction.

Examples of GLP-1 receptor agonists that act exclusively via GLP-1 receptor activation (GLP-1–only agents) include semaglutide, liraglutide, dulaglutide, exenatide, and lixisenatide.

Tirzepatide has an additional mechanism of action beyond GLP-1 receptor agonism. It activates both the glucose-dependent insulinotropic polypeptide (GIP) receptor and the GLP-1 receptor, resulting in enhanced insulin secretion, improved metabolic efficiency, appetite suppression, and greater improvements in glycaemic control and body weight compared with GLP-1 receptor agonism alone.



2. Scope

The scope of this adjudication rule highlights the medical indications and coverage requirements of GLP-1 receptor agonists for type 2 diabetes and obesity management for all health insurance plans administered by Daman as per policy terms and conditions.

3. Adjudication Policy

3.1 Eligibility / Coverage Criteria

3.1.1 Type 2 Diabetes Mellitus

GLP-1 RA therapy is indicated in adults with type 2 diabetes who have established Atherosclerotic Cardiovascular Disease, established chronic kidney disease (CKD) with cardiovascular disease (CVD), or multiple cardiovascular risk factors, using an agent with proven cardiovascular benefit as part of comprehensive cardiovascular risk reduction or glucose lowering therapy.

Atherosclerotic Cardiovascular Disease (ASCVD) is considered present with established cardiovascular disease including history of myocardial infarction (MI), stroke, or any coronary, carotid, or peripheral revascularization procedure, with some cardiovascular outcome trials also including transient ischemic attack (TIA), unstable angina, amputation related to vascular disease, and symptomatic or asymptomatic coronary artery disease; Chronic Kidney Disease (CKD) is considered present when the patient has confirmed eGFR <60 mL/min/1.73 m² or albuminuria with ACR ≥3.0 mg/mmol (≥30 mg/g).

3.1.1.1 Initiation Criteria

GLP-1 RA therapy may be initiated only if **ALL** of the following criteria are met:

a) Confirmed diagnosis of Type 2 Diabetes Mellitus with Atherosclerotic cardiovascular disease or multiple cardiovascular risk factors

b) HbA1c ≥ 6.5%, supported by a valid medical/laboratory report at the time of initial request.

c) Documented inadequate glycaemic control despite optimized antidiabetic therapy, including treatment with metformin or other appropriate antidiabetic agents for a minimum of six (6) months, or documented intolerance or contraindication to such therapy.
For patients with chronic kidney disease (CKD), there must be evidence of inadequate response to a sodium–glucose cotransporter-2 (SGLT2) inhibitor despite appropriate use, or a documented contraindication to SGLT2 inhibitor therapy

d) No contraindications to GLP-1 RA therapy, including:

- Multiple Endocrine Neoplasia (MEN) type 2
- Personal or family history of medullary thyroid carcinoma
- History of pancreatitis
- Type 1 diabetes mellitus or diabetic ketoacidosis
- Pregnancy or breastfeeding

- Known hypersensitivity to GLP-1 RA therapy

3.1.1.2 Duration Limit – Initial Request (DoH Providers):

The duration of any new GLP-1 RA therapy request, including both initiation and switching, should be submitted with a maximum initial supply of one (1) month.

3.1.1.3 Continuation and re-assessment Criteria:

A reassessment of therapy effectiveness will be conducted after 12 months of treatment to determine the appropriateness of ongoing therapy. Continuation of GLP-1 RA therapy should only proceed if the patient demonstrates a meaningful metabolic benefit, defined as:(Any of the below)

a) HbA1c reduction from initiation (**≥ 1.0 % HbA1c reduction**)

b) Improvement of clinician-documented outcomes related to comorbidities.

3.1.1.4 Stop Therapy Criteria

Contraindication or clinically significant adverse effect develops that requires cessation of GLP-1 RA therapy.

3.1.1.5 Switching Criteria

Switching between GLP-1 RA agents may be considered if:

a) there is a Lack of response after ≥6 months:

- No HbA1c reduction **OR**
- No improvement in comorbidity outcomes

b) A documented contraindication or adverse effect requiring a change in therapy (e.g., severe gastrointestinal effects).

3.1.2 Obesity management

Pharmacologic treatment with tirzepatide, semaglutide, or liraglutide(***Table 1***) for obesity management is indicated for patients with a BMI ≥40 kg/m², or a BMI ≥30 kg/m² with associated comorbidities and should be considered only after failure of comprehensive lifestyle interventions, defined as inadequate weight loss or achievement of a weight-loss plateau. Initiation of therapy requires a licensed physician to conduct a thorough discussion with the patient regarding the benefits of the medication, limitations, mechanism of action, potential adverse effects, monitoring requirements, and the expected impact on patient motivation and adherence

Covered under Thiqa policy (C1 and C2) for patients enrolled in the Thiqa obesity program through selected providers-Obesity and Morbid Obesity management

3.1.3 Metabolic dysfunction-associated steatohepatitis (MASH)

Metabolic Dysfunction-Associated Steatohepatitis (MASH), formerly known as non-alcoholic steatohepatitis (NASH), is an advanced and serious form of fatty liver disease. It occurs when excess fat accumulation in the liver leads to persistent inflammation and hepatocellular injury, which may progress to liver scarring (fibrosis) and, in advanced stages, cirrhosis and liver-related complications.

3.1.3.1 Initiation Criteria

Wegovy may be initiated only if **ALL** of the following criteria are met:

a) Patient is ≥18 years of age

b) Liver Disease Severity

- Patient has no evidence of cirrhosis (F4 fibrosis)

c) Fibrosis Confirmation (Required Documentation)

Patient has stage F2 or F3 hepatic fibrosis, documented prior to treatment initiation by ONE of the following:

- Liver biopsy
- Vibration-controlled transient elastography (VCTE)
- Magnetic resonance elastography (MRE)
- Enhanced Liver Fibrosis™ (ELF) test, with a score ≥9.2 to ≤10.5

d) The patient has at least ONE of the following metabolic risk factors, managed in accordance with standard of care:

- Central obesity;
- Hypertriglyceridemia;
- Reduced high-density lipoprotein (HDL) cholesterol;
- Hypertension;
- Elevated fasting plasma glucose (diabetes or pre-diabetes)

e) Patient has no contraindications to GLP-1 RA therapy, including:

- Personal or family history of medullary thyroid carcinoma;
- Multiple endocrine neoplasia type 2 (MEN-2);
- History of pancreatitis.

3.1.3.2 Continuation Criteria

Re-assessment will be conducted **after one year** of continuous treatment and Continuation of Wegovy therapy may be approved if ALL of the following criteria are met:

a) Liver Disease Status

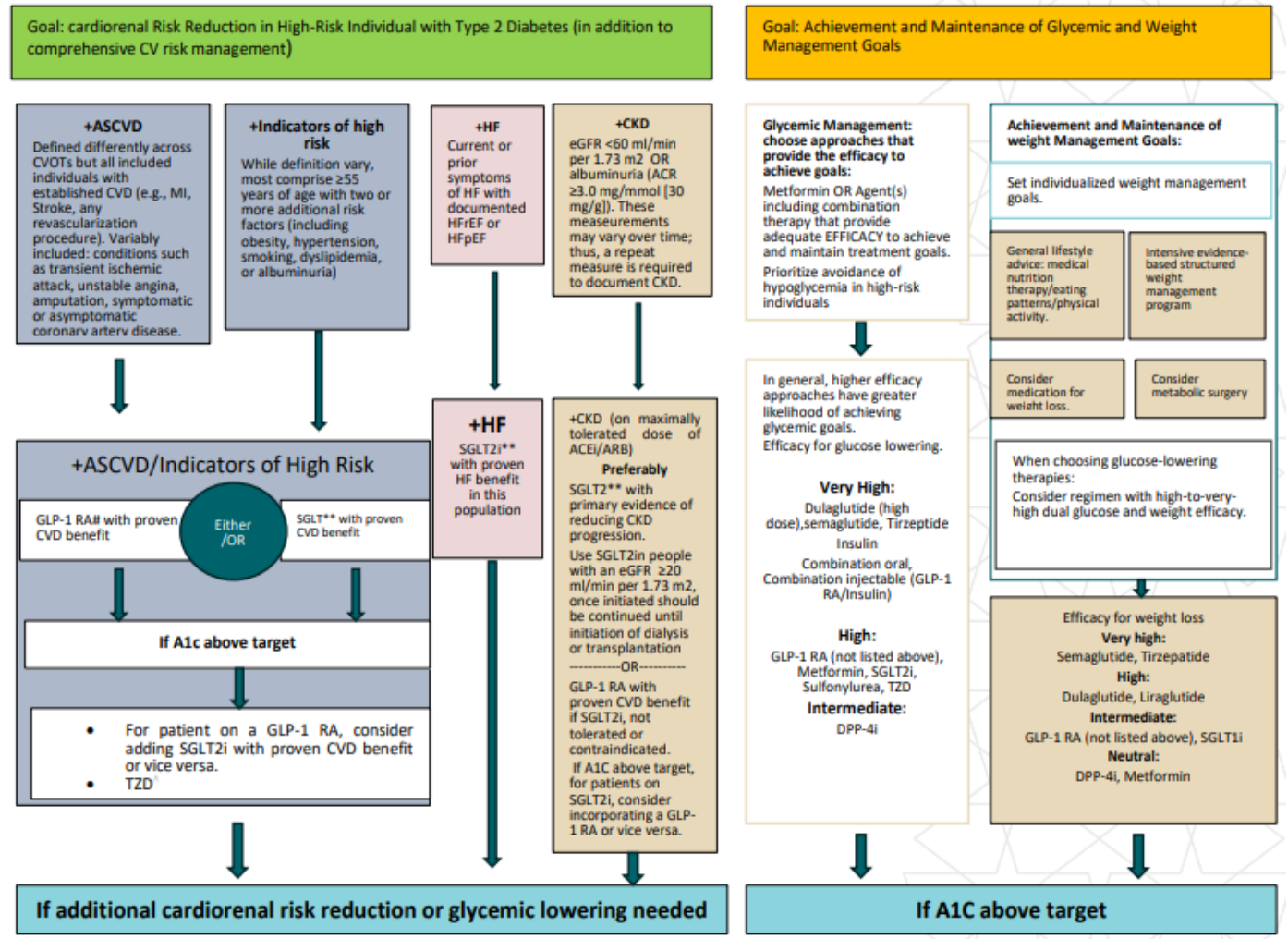
- The patient have no evidence of cirrhosis (F4 fibrosis) or hepatic decompensation; **and**
- There is no progression to cirrhosis during the course of treatment.

b) Evidence of Clinical Benefit (at least ONE required)

There must be documented improvement or stabilization of liver disease, demonstrated by one or more of the following criteria.

- Improvement or stabilization of non-invasive fibrosis assessment, such as vibration-controlled transient elastography (VCTE), magnetic resonance elastography (MRE), or Enhanced Liver Fibrosis (ELF) score; **or**
- Improvement or normalization of liver enzymes (ALT and/or AST), consistent with a clinically meaningful response; **or**
- Treating physician's documentation confirming disease stabilization or improvement, based on overall clinical assessment

Healthy Lifestyle Behaviors; Diabetes Self-Management Education and Support (DSMES); Social Determinants of Health (SDOH)



* In people with HF, CKD, established CVD, or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be independent of background use of metformin; † A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high CV risk. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details; ^ Low-dose TZD may be better tolerated and similarly effective; § For SGLT2i, CV/renal outcomes trials demonstrate their efficacy in reducing the risk of composite MACE, CV death, all-cause mortality, MI, HHF, and renal outcomes in individuals with T2D with established/high risk of CVD; # For GLP-1 RA, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and renal endpoints in individuals with T2D with established/high risk of CVD.

DOH Standard for Diagnosis and Management of Diabetes Mellitus (Reference -Link)

Dosing Guidelines & Allowable Quantities for GLP-1 Receptor Agonists:

Table:1

Drug Name	Indications	Initial Dose	Dose Optimization	Maximum Allowed boxes per Month
Tirzepatide (Mounjaro)	Type 2 Diabetes Mellitus Obesity Management	2.5 mg subcutaneously once weekly for 4 weeks	If additional glycemic control is needed, increase in 2.5 mg increments after ≥4 weeks on current dose.	1
Dulaglutide (Trulicity)	Type 2 Diabetes Mellitus	0.75 mg Subcutaneously once weekly	The maximum dose is 4.5 mg once weekly.	1
Exenatide (Byetta)	Type 2 Diabetes Mellitus	5 mcg Subcutaneously twice daily	Increase to 10 mcg twice daily.	1
Exenatide (Bydureon)	Type 2 Diabetes Mellitus	2 mg Subcutaneously once weekly	NA	1
Liraglutide (Saxenda/ Fitura)	Obesity Management	0.6 mg Subcutaneously once daily × 1 week	Increase by 0.6 mg weekly until reaching 3 mg once daily (maintenance dose)	1
Liraglutide (Victoza/ LIRADIAB)	Type 2 Diabetes Mellitus	0.6 mg Subcutaneously daily for 1 week	Increase to 1.2 mg daily; may increase to 1.8 mg daily if tolerated.	1
Lixisenatide (Lyxumia)	Type 2 Diabetes Mellitus	10 mcg Subcutaneously daily for 14 days	Increase to 20 mcg daily.	1
Semaglutide (Ozempic)	Type 2 Diabetes Mellitus	0.25 mg Subcutaneously weekly for 4 weeks	Increase to 0.5 mg weekly; max dose 1 mg weekly.	1
Semaglutide (Rybelsus)	Type 2 Diabetes Mellitus	3 mg orally once daily for 30 days	Increase to 7 mg daily; may increase to 14 mg daily if tolerated.	1
Semaglutide (Wegovy)	Obesity management and Metabolic Dysfunction–Associated Steatohepatitis (MASH)	Initiate 0.25 mg subcutaneously once weekly for 4 weeks	Increase in 4-week intervals until 2.4 mg reached. Maintenance dose is 2.4 mg subcutaneously once weekly A maintenance dose of 1.7 mg once weekly may be used if 2.4 mg is not tolerated.	1
Foundayo (orforglipron)	Obesity Management	0.8 mg **orally once daily**	Start: 0.8 mg orally once daily After ≥30 days: increase to 2.5 mg once daily After ≥30 days on 2.5 mg: increase to 5.5 mg once daily	1

			Further titration: may increase every ≥30 days to 9 mg → 14.5 mg → 17.2 mg daily based on response and tolerability Maximum dose: 17.2 mg once daily	

3.2 Requirements for Coverage

- Failure to submit, upon request or when requesting a clinical history, an indication and the need for testing will result in the rejection of the claim.

Below is the list of eligible clinician specialty

Table:2

Eligible clinician specialties
Internal Medicine
Endocrinology
Family Medicine
Cardiologist

3.3 Non-coverage

- GLP-1 RA medications for Diabetes and MASH will not be covered if medical necessity criteria are not met.
- GLP-1 RAs medications indicated for obesity management are not covered for members who are not enrolled in the Thiqa Obesity Program.
- Medications not listed in the approved formulary are not covered for policies that are subject to a medication formulary.

3.4 Payment and Coding Rules

- Please apply regulator payment rules and regulations and relevant coding manuals for ICD, CPT, etc

4. Denial Codes

DOH denial codes with description are elaborated for reference. These are specialized codes directed by DOH, that explains the reason of rejection of the service by DAMAN to the providers.

Table:3

Code	Code Description
MNEC-004	Service is not clinically indicated based on good clinical practice, without additional supporting diagnosis/activities.
MNEC-005	Services/supply may be appropriate but too frequent.
AUTH-001	Prior approval is required and was not obtained.
CLAI-016	Incorrect billing regime.
MNEC-006	Alternative service should have been utilized-Medical Justification is required
CLAI-012	Missing / invalid Duration

5. Appendices

5.1 References

1. doh.gov.ae%2F-2Fmedia%2FCB9099900C0D44BAAEA3B49E4DD73BED.ashx&usg=AOvVaw3Sb_FwujFSWI-fzXum42Qp&opi=89978449
2. Standards of Care in Diabetes | ADA Clinical Guidelines
3. https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022341lbl.pdf
4. https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/125469s007s008lbl.pdf
5. https://www.ema.europa.eu/en/medicines/human/EPAR/bydureon
6. https://www.ema.europa.eu/en/documents/product-information/ozempic-epar-product-information_en.pdf
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10. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/215866s000lbl.pdf
11. Tirzepatide 10mg solution for injection in pre-filled pen - Summary of Product Characteristics(SmPC)(emc)(medicines.org.uk)
12. https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/215866s041lbl.pdf

5.2 Revision History

Table:4

Date	Change(s)
24/05/2023	Release of V1.0
08/09/2023	Release of V2.0-Tirzepatide criteria addition
28/04/2026	- GLP-1 Receptor Agonist Indications -Add MASH and Obesity - GLP-1 switching criteria for Diabetes treatment -Required documents for MASH indication -Added new Oral GLP-1 Medication-orforglipron