Tirzepatide (MOUNJARO) Injection
Criteria for Use
August 2022

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. **THE CLINICIAN SHOULD UTILIZE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.**

Exclusion Criteria

If any of the following are selected, patient should not receive tirzepatide

- ☐ Diagnosis of Type 1 diabetes
- ☐ Personal or family history of medullary thyroid carcinoma or with Multiple Endocrine Neoplasia syndrome type 2
- ☐ Severe gastrointestinal dysmotility including gastroparesis
- ☐ History of pancreatitis (does not pertain to patients for whom the cause of pancreatitis is known and no longer presents a risk)
- ☐ Pregnancy^1
- ☐ Known PDR, severe NPDR, clinically significant ME, or DME unless risks/benefits have been discussed with the patient and is documented in the EHR along with monitoring plans and follow-up with an eye specialist who is informed at the time of initiation ^2

Relative Exclusion

- ☐ Risk factors for pancreatitis (e.g., untreated fasting triglyceride level > 1000mg/dL, known gallstones with intact gallbladder, alcohol use disorder)

Abbreviations: DME=diabetic macular edema; EHR=electronic health record; ME=macular edema; NPDR=nonproliferative diabetic retinopathy; PDR=proliferative diabetic retinopathy

1. **Insulin is generally the preferred treatment during pregnancy**. Based on animal reproduction studies, there is a potential for embryo-fetal toxicity from tirzepatide exposure during pregnancy. Use during pregnancy only if the potential benefit justifies the potential risk to the fetus and mother

2. Rapid improvement in glucose control has been associated with temporary worsening of diabetic retinopathy. Tirzepatide has not been studied in patients with NPDR requiring acute therapy, PDR, or DME. Before considering tirzepatide, the provider should have the results of diabetic eye examination completed within past 12 months on file. Decision to use tirzepatide should consider disease severity and activity. Patients with a history of diabetic retinopathy should have planned follow-up with the eye provider to monitor for progression. Consultation with an eye care specialist should be obtained any time there are concerns related to use in patients with diabetic retinopathy.

Inclusion Criteria

All of the following must be met

- ☐ Diagnosis of Type 2 diabetes
- ☐ Inadequate glycemic control on at least 1mg of semaglutide injection plus two or more glucose lowering drugs (metformin, empagliflozin, insulin, pioglitazone, sulfonylurea) for at least 6 months^3-8
- ☐ Change needed to achieve goal A1C is less than 1%.^9 Goal A1C should be based on those recommended in the VA/DoD Diabetes Guidelines

Updated version may be found at *PBM INTERnet* or *PBM INTRAnet*

☐ Adherent to current diabetes medications as evidenced by a review of prescription refill history during the last 6 months

☐ Current non-GLP 1A drugs are optimized as appropriate

Additional Inclusion Criteria Select if Applicable

☐ Patients with atherosclerotic cardiovascular disease (ASCVD) or chronic kidney disease (CKD) are receiving empagliflozin unless unable to use^10

☐ Patients of childbearing potential who are using oral contraceptives have been counseled to switch to a non-oral contraceptive method or add a barrier method of contraception for 4 weeks after initiation and for 4 weeks after each dose escalation

3. It is recommended that patients receiving liraglutide or exenatide be switched to a trial of semaglutide before considering tirzepatide. Patients receiving maximally tolerated doses of dulaglutide can be switched to tirzepatide if the other criteria for tirzepatide are met.
4. Patients with a history of intolerance to semaglutide should be offered a trial of another GLP1A before going to tirzepatide.
5. Empagliflozin is recommended for overweight patients, particularly those with BMI greater or equal to 27kg/m2, unless unable to use
6. Consider insulin at any time prior to using tirzepatide, unless unable to use or otherwise inappropriate
7. Do not use tirzepatide in combination with GLP-1 agonists or DPP-4 inhibitors. Concomitant use with alpha glucosidase inhibitors, meglitinides is not recommended due to lack of or insufficient data regarding their combined use.
8. There are no data, at present, combining tirzepatide with both basal and prandial insulin (including premixed formulations) or with U500 insulin. Concomitant use of tirzepatide with these insulin regimens may be done on a case-by-case basis in consultation with an endocrinologist or diabetes specialist.
9. In SURPASS-2, the A1C treatment difference between tirzepatide 15mg (highest dose) and semaglutide 1mg was -0.45 [95%CI -0.57, -0.32]. Therefore, it is not expected that switching from semaglutide to tirzepatide would provide adequate A1C lowering for patients who are significantly above goal A1C.
10. Primary outcome results for the tirzepatide cardiovascular outcomes trial (SURPASS-CVOT) are not expected until October 2024. Until SURPASS-CVOT is completed, patients with established ASCVD or CKD should ideally be on empagliflozin for its cardiorenal benefits when switching from semaglutide to tirzepatide.

Contact: Deb Khachikian, PharmD National Clinical Pharmacy Program Manager, VA Pharmacy Benefits Management Services 10P4P