Semaglutide (OZEMPIC) Injection
Criteria for Use
July 2021
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

☐ Type 1 diabetes
☐ Personal or family history of medullary thyroid carcinoma or with Multiple Endocrine Neoplasia syndrome type 2
☐ Severe gastrointestinal disease (e.g., gastroparesis)
☐ History of pancreatitis (does not pertain to patients for whom the cause of pancreatitis is known and no longer presents a risk)

Relative Exclusions

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

*In SUSTAIN-6, more events of diabetic retinopathy (DR) complications occurred in patients treated with injectable semaglutide (3.0%) compared to placebo (1.8%). The absolute risk increase for DR complications was larger among patients with a history of DR at baseline (semaglutide 8.2%, placebo 5.2%) than among patients without a known history of DR (semaglutide 0.7%, placebo 0.4%). Before considering injectable semaglutide the provider should have the results of diabetic eye examination completed within past 12 months on file. Decision to use semaglutide should take into account disease severity and activity. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy.

**Insulin is generally the preferred treatment during pregnancy. GLP-1 agonists should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Note: Per labeling for semaglutide: discontinue semaglutide in women at least 2 months before a planned pregnancy due to the long washout period for semaglutide.

Inclusion Criteria

Patients WITH Atherosclerotic Cardiovascular Disease and/or Chronic Kidney Disease

☐ Type 2 diabetes AND receiving metformin unless unable to use metformin
☐ Not a good candidate for empagliflozin¹

AND at least ONE of the following:

☐ Established atherosclerotic cardiovascular disease
☐ eGFR <60mL/min/1.73m² OR Urinary Albumin-to-Creatinine Ratio >= 30mg/g

Atherosclerotic Cardiovascular Disease: history of acute coronary syndrome or myocardial infarction, stable or unstable angina, coronary heart disease with or without revascularization, other arterial revascularization, stroke, or peripheral artery disease assumed to be atherosclerotic in origin.

Patients WITHOUT Atherosclerotic Cardiovascular Disease and/or Chronic Kidney Disease

☐ Type 2 diabetes
☐ Inadequate glycemic control on two or more oral medications, ideally one of which should be metformin²⁻⁴

OR

November 2020 (rev July 2021); replaces GLP1 Agonist CFU
Updated versions may be found at PBM INTERnet or PBM INTRAnet
Inadequate glycemic control on basal insulin, titrated as feasible, to an acceptable fasting blood glucose level, plus an oral medication(s), ideally metformin\(^5\,^6\)

Reserve oral semaglutide (nonformulary) for those unable to use injectable therapy (e.g., dexterity or vision limitations, etc.). Consider other formulary oral agents before using oral semaglutide.

\(^1\)Risks for empagliflozin may include volume depletion, genitourinary tract infections, and ketoacidosis. Refer to package labeling or empagliflozin criteria for use for more information.

\(^2\)Refer to the VA/DoD Diabetes Guidelines [https://www.healthquality.va.gov/](https://www.healthquality.va.gov/) for recommendations on individualizing A1C targets

\(^3\)GLP-1 agonists in combination with alpha glucosidase inhibitors, meglitinides or DPP-4 inhibitors are not recommended due to lack of or insufficient data regarding their combined use.

\(^4\)Insulin may be considered at any time prior to using a GLP-1 agonist; however, insulin is preferred if patient is symptomatic or the desired A1C reduction is beyond what is achievable by a GLP-1 agonist. In clinical trials the mean reduction in A1C when semaglutide is added to oral hypoglycemic agents ranges from 1.3% to 1.5%.

\(^5\)Consider addition of mealtime insulin instead of using a GLP-1 agonist; however, mealtime insulin should be used if patient is symptomatic or the desired A1C reduction is beyond what is achievable by a GLP-1 agonist. In clinical trials the mean reduction in A1C when used with basal insulin was 1.3% and 1.7% for semaglutide 0.5mg and 1.0mg respectively.

\(^6\)The data for GLP-1 agonists in combination with both basal and prandial insulin or with U500 insulin are very limited at present. Concomitant use of GLP-1 agonists with regimens containing basal insulin AND prandial insulin (including premixed formulations) or with U500 may be done on a case-by-case basis in consultation with an endocrinologist or diabetes specialist.