

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Weight Loss Management

Drug Requested: (check box below that applies)

PREFERRED MEDICATIONS *Require prior authorization	
<input type="checkbox"/> orlistat	<input type="checkbox"/> Xenical® (orlistat)
<input type="checkbox"/> phendimetrazine IR and ER	<input type="checkbox"/> phentermine 15mg/30mg/37.5mg
<input type="checkbox"/> diethylpropion IR and ER	<input type="checkbox"/> benzphetamine
NON-PREFERRED MEDICATIONS *Saxenda, Wegovy, Zepbound requires trial and failure of one (1) oral preferred agent For Wegovy and Zepbound: the member has tried and failed the selected product, Saxenda, as indicated on the PDL.	
<input type="checkbox"/> Saxenda® (liraglutide) *12 and older	<input type="checkbox"/> Wegovy® PEN (semaglutide) *12 and older
<input type="checkbox"/> Imcivree™ (setmelanotide) *2 and older	<input type="checkbox"/> Zepbound™ (tirzepatide) *18 and older
<input type="checkbox"/> Lomaira™ (phentermine HCL) *16 and older	<input type="checkbox"/> phentermine/topiramate ER *12 and older
<input type="checkbox"/> liraglutide (generic Saxenda®)*12 and older	<input type="checkbox"/> Wegovy® Tablets (semaglutide) *18 and older <u>(requires additional documentation why injection cannot be utilized)</u>

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Request Requirements:

- Provider must submit current height and weight measurements (**verified by chart notes from within the last 60 days**)

Height: _____ **Current Weight:** _____ **BMI:** _____ **Date:** _____

Coverage for all medications will be limited to the following:

Absence of medical contraindications:

- No contraindications to use; (i.e. uncontrolled hypertension, hyperthyroidism etc. for stimulant based products); **AND**
- No malabsorption syndromes, cholestasis, pregnancy and/or lactation (for orlistat); **AND**
- No history of an eating disorder (e.g., anorexia, bulimia); **AND**
- No acute pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome (if requesting a GLP-1 Receptor Agonists); **AND**

Additional qualifying criteria to include the following: (excludes Imcivree™)

- Participation in nutritional counseling; **AND**
- Participation in physical activity program, unless medically contraindicated; **AND**
- Commitment to continue the above weight-loss treatment plan; **AND**

The provider attests that the patient's obesity is disabling and life threatening (i.e., puts the patient at risk for high-morbidity conditions):

- Yes
- No

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Written documentation must include the following:

- Current medical status and weight loss plan from within the last 60 days. An individualized weight loss program should include a specific reduced calorie meal plan, recommended routine physical activity, and behavioral intervention including lifestyle modification as needed to improve adherence and outcomes
- Accurate height and weight measurements from within the last 60 days

Document details of previous weight loss treatment plans to include diet and exercise plans, in addition to submitting a copy of the plan:

Drug Specific Requirements (Minimum ages are per FDA approvals):

1. For phentermine (min age 17), phendimetrazine tablet (min age 18), phendimetrazine ER capsule (min age 17) orlistat (min age 12) and phentermine/topiramate (age 18 and older):
 - Body mass index (BMI) $\geq 30\text{kg/m}^2$, if no applicable risk factors; **OR**
 - Body mass index (BMI) ≥ 27 with **at least one** weight-related comorbidity:

<input type="checkbox"/> coronary heart disease	<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> hypertension
<input type="checkbox"/> sleep apnea	<input type="checkbox"/> Type II Diabetes	

2. For benzphetamine (min age 17), diethylpropion (min age 16) and phentermine/topiramate (age 12-17):
 - Body mass index (BMI) $\geq 30\text{kg/m}^2$
3. For Imcivree[®] (min age 2)
 - BMI $\geq 30\text{ kg/m}^2$; **AND**
 - Prescribed by or in consultation with an endocrinologist or geneticist; **AND**
 - Member has Bardet-Biedl syndrome (BBS); **OR**
 - Member has proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test; **AND**
 - Member’s genetic variants are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS)

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4. For GLP-1 receptor agonists indicated for weight loss (Wegovy/Saxenda/liraglutide min age 12, Zepbound min age 18):

- BMI > 40 kg/m², if no applicable risk factors; **OR**
- BMI > 37 kg/m² with one or more of the following risk factors:

<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> hypertension	<input type="checkbox"/> Type II Diabetes
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- Member has tried and failed one of the non-GLP1 weight-loss medications*; **OR**
- Member is intolerant to all non-GLP1 weight-loss medications*; **AND**
- Member not concurrently on another GLP-1 receptor agonists; **AND**
- The member has tried and failed* the selected product, brand Saxenda[®], as indicated on the PDL: <https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list/>

*Definitions of Accepted Drug Trial	
Drug	Trial
Benzphetamine, diethylpropion, phendimetrazine, phentermine, phentermine/topiramate	3-month trial without a weight loss of 10lbs
Orlistat	6-month trial without a weight loss of 10lbs
GLP-1 Receptor Agonist	6-month trial without a body weight reduction of 5%

Length of Authorization:

- Initial request:** Varies (drug specific)
 - Benzphetamine, diethylpropion, phendimetrazine, phentermine, phentermine/topiramate- **3 months**
 - GLP-1 receptor agonists- **6 month**
 - Orlistat- **6 months**
 - Imcivree[™] - **4 months**
- Renewal requests:** Renewals will no longer be granted once a member reaches a BMI < 25. **Renewals must be submitted within 30 days of the most recent authorization expiration date or request may be reviewed as a new start. See additional requirements below (drug specific):**
 - **Benzphetamine, diethylpropion, phendimetrazine, phentermine, phentermine/topiramate** – If patient achieves at least a 10-lb weight loss during initial 3 months of therapy, an additional 3-month prior authorization may be granted. Maximum length of continuous drug therapy = 6 months **(waiting period of 6 months before next request)**
 - **Xenical® (orlistat)**- If patient achieves at least a 10-lb weight loss, an additional 6-month prior authorization may be granted. Maximum length of continuous drug therapy = 24 months **(waiting period of 6 months before next request)**
 - **Imcivree™** – If the member has experienced ≥ 5% reduction in body weight (or ≥ 5% of baseline BMI in those with continued growth potential), an additional 1-year prior authorization may be granted
 - **GLP-1 Receptor Agonists** – If the member achieves a weight loss of ≥ 5% reduction in body weight compared to the most recent authorization, an additional 6-month SA may be granted

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Current measurements: BMI (Adult) or % of 95th percentile weight (12-17 y/o):

Height: _____ Weight: _____ BMI: _____ DATE: _____ (attach chart notes)

Previous authorization measurements: BMI (Adult) or % of 95th percentile weight (12-17 y/o):

Height: _____ Weight: _____ BMI: _____ DATE: _____ (attach chart notes)

All approvals are subject to the criteria on this form. Existing authorizations will be honored until renewal.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****