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

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 <u>previous weight loss treatment plans</u> to include diet and exercise plans, in addition to submitting a copy of the plan:

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<u>Drug Specific Requirements (Minimum ages are per FDA approvals):</u>

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) ≥ 30kg/m^2, if no applicable risk factors; **OR**
   - ❑ Body mass index (BMI) ≥ 27 with **at least one** weight-related comorbidity:

❑ coronary heart disease	❑ dyslipidemia	❑ hypertension
❑ sleep apnea	❑ Type II Diabetes	

2. For benzphetamine (min age 17), diethylpropion (min age 16) and phentermine/topiramate (age 12-17):
   - ❑ Body mass index (BMI) ≥ 30kg/m^2
3. For Imcivree® (min age 2)
   - ❑ BMI ≥ 30 kg/m^2; **AND**
   - ❑ Prescribed by or in consultation with an endocrinologist or geneticist; **AND**
   - ❑ Member has acquired hypothalamic obesity; **OR**
   - ❑ 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 injections [min age 12], Foundayo [min age 18], Wegovy HD/ tablet [min age 18] Zepbound [min age 18]):
   - ❑ BMI > 40 kg/m^2, if no applicable risk factors; **OR**
   - ❑ BMI > 37 kg/m^2 with one or more of the following risk factors:

❑ dyslipidemia	❑ hypertension	❑ Type II Diabetes

   - ❑ 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, Wegovy Pen® (excludes HD), as indicated on the PDL: https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list/
5. For oral GLP- receptor agonists, in addition to confirmation of criteria in #4 above, please provide documentation of a medical contraindication to an injectable product OR documented trial and failure of two injectable products

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_____

*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**

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- **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

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

Height: _____ Current Weight: _____ BMI: _____ Date: _____ (attach chart notes)

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

Height: _____ Current 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.****

REVISED/UPDATED/REFORMATTED: ~~8/27/2017; 12/24/2017; 3/22/2018; 8/16/2018; 4/1/2019; 1/8/2021; 8/11/2021; 11/12/2021; 4/21/2022; 7/8/2022; 12/27/2022; 3/2/2023, 12/21/2023; 1/18/2024, 4/3/2024; 5/15/2024; 6/19/2024; 9/6/2024, 9/22/2024, 10/02/2024; 10/16/2024; 02/18/2025; 7/17/2025; 7/30/2025 , 9/10/2025, 10/24/2025, 1/29/2026; 6/10/2026; 6/19/2026; 7/13/2026,~~ **8/6/2026**