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	
❑ **Adipex-P®/Suprenza™ (**phentermine HCl)	❑ **Xenical®** (orlistat)
❑ **Bontril®/Bontril PDM®** (phendimetrazine)	❑ **Radtue®** (diethylpropion)
❑ **Didrex®/Regimex®** (benzphetamine)	❑ **Wegovy®** (semaglutide)*
❑ **Saxenda®** (liraglutide)*	
*Requires trial and failure to one (1) oral non-GLP product	
NON-PREFERRED MEDICATIONS ***requires trial and failure of 2 preferred agents**	
❑ **Imcivree™**(setmelanotide)	❑ **Zepbound™** (tirzepatide)*

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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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.

Coverage for these medications will be limited to the following:

1. **BMI requirements**

(Adipex-P®/Suprenza™, Bontril®/Bontril PDM®, Didrex®/Regimex®, Xenical®, Radtue):

- ❑ Body mass index (BMI) ≥ 30, if no applicable risk factors
- ❑ Body mass index (BMI) ≥ 27 with **two or more** of the following risk factors:

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

Saxenda®, Wegovy® (Preferred agents- require trial and failure to one (1) oral non-GLP), Zepbound® (Non-preferred agent- requires trial and failure of two (2) preferred agents):

- ❑ Body mass index (BMI) ≥ 27 with **two or more** of the following risk factors:

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

OR

- ❑ Body mass index (BMI) ≥ 30, if no applicable risk factors **AND**
- ❑ A 30-day trial and failure or intolerance to a non-GLP-1 weight loss drug with a description or reason for failure or intolerance 6 months prior to request.
- ❑ For patients 12-17 years of age, a BMI that is ≥ 140% of the 95th percentile by age and sex.
- ❑ For patients 12-17 years of age, a BMI that is ≥ 120% of the 95th percentile by age and sex with two or more of the following risk factors:

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

Imcivree™

- ❑ Body mass index (BMI) ≥ 30 or > 95th percentile on pediatric growth chart

2. **Age restrictions:**
   - ❑ Covered only for members 16 years or older
   - ❑ Saxenda® only covered for members 12 years or older
   - ❑ Imcivree™ only covered for members 6 years or older
   - ❑ Wegovy® only covered for members 12 years or older
   - ❑ **Zepbound™** (tirzepatide) only covered for members 18 years or older
3. **Initial Request Requirements**:
   - ❑ No contraindications to use; AND
   - ❑ No malabsorption syndromes, cholestasis, pregnancy and/or lactation; **AND**
   - ❑ No history of an eating disorder (e.g., anorexia, bulimia); **AND**

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- ❑ Previous failure of a weight loss treatment plan **(e.g., nutritional counseling, an exercise regimen and a calorie/fat-restricted diet)** in the **past 6 months** and will continue to follow as part of the total treatment plan **(excludes Imcivree™)**

Specific to Imcivree™ ONLY:

- ❑ Prescribed by or in consultation with an endocrinologist or geneticist; **AND**
  - ❑ 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) **OR**
  - ❑ Member has Bardet-Biedl syndrome (BBS)

4. 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
5. **The written documentation must include:**
   - ❑ Current medical status and weight loss plan. 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.
   - ❑ Current dated accurate height and weight measurements
   - ❑ No medical contraindications to use a reversible lipase inhibitor **(Xenical®)**
   - ❑ If applicable, a 30-day trial and failure or intolerance to a non-GLP-1 weight-loss drug with a description or reason for failure or intolerance. **(Saxenda®, Wegovy® and Zepbound™)**
   - ❑ Member not concurrently on Victoza® or Ozempic® or other GLP-1 agonists **(Saxenda® Wegovy® and Zepbound™)**
6. If the physician does not have the necessary information, the request will be denied and the fax form requesting additional information will be sent to the prescriber.
7. **Length of Authorization:**
   - ❑ **Initial request:** Varies (drug specific)
     - Benzphetamine, diethylpropion, phendimetrazine, phentermine -- 3 months
     - Xenical®, Wegovy® Zepbound™-- 6 months
     - Saxenda® and Imcivree™ -- 4 months
   - ❑ **Renewal requests:** Varies (drug specific)
     - **Benzphetamine, diethylpropion, phendimetrazine, phentermine** – 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®** - 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)

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- **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
- **Saxenda®** - If patient achieves a weight loss of at least 4% of baseline weight, additional 6- month prior authorization may be granted as long as weight reduction continues
- **Wegovy® /Zepbound™--**If patient achieves a weight loss of at least 5% of baseline weight,
- additional 6- month prior authorization may be granted as long as weight reduction continues
- Members lacking a weight loss response may still be considered for renewal with two or more of the following weight related risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes.
- **At this time, authorization requests over one year are subject to initial criteria including all documentation.**
- In the event of an FDA recognized shortage, approved members will be eligible for the full allotment of approved drug once the shortage is resolved.

1. **Assessment:** _____
2. **Other Diagnoses/Risk Factor** _____
3. **Current medications:** _____
4. **Current body mass index (BMI):** _____ **Height:** _____ **Weight:** _____ (attach chart notes)

Document details of previous weight loss treatment plans to include diet and exercise plans. Submit copy of plan. Additional Comments:

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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.

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