

# AvMed

## 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 1-305-671-0200.** 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.**

### Group Specific Benefit

**Drug Requested:** **Weight Management Drugs** (select one of the following)

<input type="checkbox"/> benzphetamine 50 mg	<input type="checkbox"/> phentermine hydrochloride USP (Lomaira™)
<input type="checkbox"/> Contrave® (naltrexone HCl/bupropion HCl)	<input type="checkbox"/> phentermine/topiramate ER (Qsymia®)
<input type="checkbox"/> diethylpropion IR/ER	<input type="checkbox"/> Wegovy® (semaglutide)
<input type="checkbox"/> liraglutide (Saxenda®)	<input type="checkbox"/> Xenical® (orlistat)
<input type="checkbox"/> phendimetrazine IR	<input type="checkbox"/> Zepbound™ Pens (tirzepatide) *Kwikpen/vial formulations are <b>NOT</b> covered
<input type="checkbox"/> phentermine HCL	

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

Member Name: \_\_\_\_\_

Member AvMed #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

NPI #: \_\_\_\_\_

**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: \_\_\_\_\_

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- Will the member be discontinuing a previously prescribed weight loss medication if approved for requested medication?

Yes **OR**  No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

**Medication to be discontinued:** \_\_\_\_\_ **Effective date:** \_\_\_\_\_

**Medication to be initiated:** \_\_\_\_\_ **Effective date:** \_\_\_\_\_

**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 Authorization: 7 months**

**Provider please note: If member was previously approved for the requested medication under an alternate health plan, please complete the reauthorization section of the PA form.**

- Member must meet **ONE** of the following age requirements:
  - 18 years of age or older
  - phentermine/topiramate ER (generic Qsymia<sup>®</sup>) only: 12 years of age or older with an initial body mass index (BMI) in the 95th percentile or greater standardized for age and sex
  - Wegovy<sup>®</sup> only: 12 years of age or older with an initial body mass index (BMI) in the 95th percentile or greater standardized for age and sex
  - liraglutide (generic Saxenda<sup>®</sup>) only: 12 years of age or older **AND** has a measured body weight of at least 60 kg (132 lbs)
- If requesting liraglutide (generic Saxenda<sup>®</sup>), Wegovy<sup>®</sup> or Zepbound<sup>™</sup>, member is **NOT** using concurrent therapy with another GLP-1 receptor agonist prescribed for another indication (e.g., Mounjaro<sup>®</sup>, Ozempic<sup>®</sup>, Trulicity<sup>®</sup>, Rybelsus<sup>®</sup>)
- Member must have participated in a weight loss treatment plan (i.e. nutritional counseling, an exercise regimen and/or a calorie/fat-restricted diet) in the past 6 months and will continue to follow this treatment plan while taking an anti-obesity medication

- Provider must submit current height and weight measurements **(verified by chart notes)**

**Height:** \_\_\_\_\_ **Current Weight:** \_\_\_\_\_ **BMI:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- Member must meet **ONE** of the following BMI requirements:
    - BMI of 30 or greater
    - BMI of 27 or greater with co-morbid conditions that may include coronary artery disease, hypertension, congestive heart failure, diabetes, dyslipidemia, or sleep apnea
- Comorbid Condition(s): \_\_\_\_\_ **(verified by chart notes)**

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**Reauthorization: up to 12 months**

**(Contingent upon member continuing to lose weight up to desired BMI; PA requests for anti-obesity drugs will not be renewed if a member's BMI is below 18.5)**

**Baseline measurements:** (Baseline is defined as body measurements obtained prior to the start of the requested medication)

Height: \_\_\_\_\_ Baseline Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Date: \_\_\_\_\_

**Current measurements:** (verified by chart notes)

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Date: \_\_\_\_\_

**All of the following reauthorization criteria must be met:**

- Member must continue with weight loss treatment plan (i.e., nutritional counseling, an exercise regimen and/or a calorie/fat-restricted diet) while on medication for weight reduction
- Member must meet **ONE** of the following:
  - Member has achieved at least a 5% decrease in their weight within the initial approval period of 7 months as documented by their physician (Initial renewal length = 7 months)
  - Member has maintained initial 5% weight loss (Subsequent renewal length = 12 months)
- Provider attests that member has **NOT** developed any negative side effects from requested medication
- Provider attests that member does **NOT** have any medical or drug contraindications to therapy with requested medication

*Not all drugs may be covered under every Plan*

*If a drug is non-formulary on a Plan, documentation of medical necessity will be required.*

***\*\*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.\****