COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

WEIGHT-LOSS MANAGEMENT

CardinalCare
Virginia's Medicaid Program

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

For initial requests, continue below. For renewal requests, proceed to page 4 of this form.

Drug Name: _____ **Drug Form:** _____

Drug Strength: _____ **Dosing Frequency:** _____

Length of Therapy: _____ **Quantity:** _____

Day Supply: _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

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.

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)

For all others except Imcivree®, additional qualifying criteria are:

☐ Participation in nutritional counseling; **AND**

☐ Participation in physical activity program, unless medically contraindicated; **AND**

☐ Commitment to continue the above weight-loss treatment plan.

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

The written documentation must include the following:

☐ 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. **AND**

☐ Current accurate height and weight measurements

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

Assessment:

(Form continued on next page.)

Member's Last Name:

Member's First Name:

Other Diagnoses/Risk Factors:

DRUG SPECIFIC CRITERIA (Minimum ages are per FDA approvals)

1. For phentermine (min age 17), phendimetrazine tablet (min age 18), phendimetrazine ER capsule (min age 17) and orlistat (min age 12):

☐ The member has a BMI of ≥ 30 kg/m^2; **OR**

☐ The member has a BMI of ≥ 27 kg/m^2 with at least one weight-related comorbidity (i.e. coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes)

2. For benzphetamine (min age 17), diethylpropion (min age 16):

☐ The member has a BMI of ≥ 30 kg/m^2

3. For Imcivree® (min age 6):

☐ BMI ≥ 30 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).

4. For GLP-1 receptor agonists indicated for weight loss (Wegovy/Saxenda min age 12, 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 2 diabetes; **AND**

☐ 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 as indicated on the PDL: https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list/

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

*Definitions of Accepted Drug Trial	
Drug	Trial
Benzphetamine, diethylpropion, phendimetrazine, phentermine	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 – 3 months
- GLP-1 receptor agonists – 6 months
- Orlistat – 6 months
- Imcivree® – 4 months

☐ **Renewal Request: Renewals will no longer be granted once a member reaches a BMI < 25. See additional requirements below (drug specific):**

- **Benzphetamine**, **diethylpropion**, **phendimetrazine**, **phentermine** – If the member achieves at least a 10-pound (lb.) weight loss during the initial 3 months of therapy, an additional 3-month SA may be granted. Maximum length of continuous drug therapy is 6 months (waiting period of 6 months before next request).
- **orlistat** – If the member achieves at least a 10-lb. weight loss, an additional 6-month SA may be granted. Maximum length of continuous drug therapy is 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 SA 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.

☐ Check if additional documents will be uploaded

(Form continued on next page.)

Member's Last Name:

Member's First Name:

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

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information. Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services. The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC/Attn: GV – 4201
P.O. Box 64811 St. Paul, MN 55164-0811