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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

WEIGHT-LOSS MANAGEMENT

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:** _____

Days Supply: _____

(Form continued on next page.)

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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 a fax form requesting additional information will be sent to the prescriber.

Coverage for these 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 GLP-1 Receptor Agonists)

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

- ☐ Participation in nutritional counseling; **AND**
- ☐ Participation in a 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:

- ☐ 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; **AND**
- ☐ Accurate height and weight measurements from within the last 60 days

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), orlistat (min age 12) and phentermine/topiramate (age 18 and older):**
   - ☐ 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 (e.g., coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes)
2. **For benzphetamine (min age 17), diethylpropion (min age 16), and phentermine/topiramate (age 12–17)**:
   - ☐ The member has a BMI of ≥ 30 kg/m^2
3. **For Imcivree® (min age 2 years):**
   - ☐ 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).
4. **For GLP-1 receptor agonists indicated for weight loss (Foundayo tablet [min age 18]), (Wegovy/Saxenda injections [min age 12]), (Wegovy HD/tablet [min age 18], Zepbound [min age 18 and member must try and fail Zepbound KwikPen prior to approval of Zepbound unit dose pen]):**
   - ☐ 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, or 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 agonist; **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:**

5. **For oral GLP-1 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:**

**A medical contraindication is a specific patient condition in which the use of an injectable product increases the risk of a severe, life-threatening allergic or biological adverse reaction.

*Definitions of Accepted Drug Trial	
Drug	**Trial**
Benzphetamine, diethylpropion, phendimetrazine, phentermine, phentermine/topiramate	3-month trial without a weight loss of 10 lbs
Orlistat	6-month trial without a weight loss of 10 lbs
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 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). Renewals must be submitted within 30 days of the most recent authorization's expiration.**

- **Benzphetamine**, **diethylpropion**, **phendimetrazine**, **phentermine, phentermine/topiramate** – 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-pound 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.

(Form continued on next page.)

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

☐ Check if additional documents will be uploaded

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:

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Attn: GV – 4201
P.O. Box 64811
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