Updated: 08/2022
DMMA Approved: 08/2022

Request for Prior Authorization for Anti-Obesity Agents
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Anti-Obesity Agents require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Anti-Obesity Agents Prior Authorization Criteria:

Anti-Obesity Agents include Adipex-P (phentermine), benzphetamine (previously known as Didrex or Regimax), Bontril PDM (phendimetrazine), Contrave (bupropion/naltrexone), diethylpropion, Lomaira (phentermine), Qsymia (phentermine/topiramate), phendimetrazine ER, Saxenda (liraglutide), Wegovy (semaglutide) and Xenical (orlistat). New products with this classification will require the same documentation.

For all requests for Anti-Obesity Agents all of the following criteria must be met:

- Member must be 18 years of age or older
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Member must meet ONE of the following:
    - has a BMI of 30 or greater
    - has a BMI of 27-29 AND one of the following co-morbid conditions:
        - Diabetes Mellitus
        - Hypertension
        - Hyperlipidemia
        - Coronary Artery Disease (Heart Bypass surgery, CABG, history of a myocardial infarction MI, history of stroke, angina)
        - Obstructive sleep apnea
- The prescriber attests to the following:
    - Member is actively involved in a dietary/behavior modification program for weight loss.
    - Member is actively following a fitness exercise regimen
- Members cannot obtain another anti-obesity agent for at least 30 days.
- **Initial Duration of Approval**: 3 months
- **Reauthorization Criteria:**
    - Documentation of member's current weight since initiating therapy.
    - Must lose at least 5% of their initial starting weight within the initial approval request (i.e. 3 months) as documented by their physician.
    - Must continue to implement diet and exercise into their weight loss plan.
    - If the member fails to maintain at least a 5% reduction from baseline, the request will be denied.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-

reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

Updated: 08/2022
DMMA Approved: 08/2022

ANTI-OBESITY AGENTS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

What is the BMI? ☐ < 27 ☐ 27-29 ☐ 30 or greater

Which of the following co-morbid conditions is present, if any:

☐ Diabetes ☐ Obstructive sleep apnea
☐ Hypertension ☐ Coronary artery disease
☐ Hyperlipidemia

Is the member actively involved in a dietary/behavior modification program for weight loss? ☐ Yes ☐ No

Is the member actively following a fitness exercise regimen? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Baseline weight: _____ Date: _____
Current weight: _____ Date: _____

Is the member continuing to include diet and exercise in their weight loss plan? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date