HIGHMARK HEALTH OPTIONS

Updated: 02/2025
DMMA Approved: 03/2025

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

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

Obesity Treatment Agents Prior Authorization Criteria:

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

For all requests, the following criteria must be met in addition to the specific criteria below:

- For non-preferred agents, must have a therapeutic failure, contraindication, or intolerance to the preferred agent(s) FDA-approved or medically accepted for the intended use.
- Is prescribed for an FDA-approved or medically accepted indication
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

Coverage **for weight reduction** may be provided when the following criteria are met:

- For members 18 years of age or older, must meet ONE of the following:
  - has a BMI of 30 kg/m^2 or greater
  - has a BMI of 27-29 kg/m^2 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
- For members under 18 years old, has a BMI $\geq 95^{th}$ percentile for age and sex based on the current CDC charts
- 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 obesity treatment agent for at least 30 days.
- **Initial Duration of Approval**: 6 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 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% weight reduction from baseline, the request will be denied.
- **Reauthorization Duration of Approval:** 6 months

Coverage of a glucacon-like peptide-1 (GLP-1) receptor agonist **to reduce the risk of major adverse cardiovascular events (MACE)** may be provided when the following criteria are met:

- Must be 45 years of age or older
- Must have a BMI $\geq$ 27 kg/m^2
- Must have established cardiovascular disease (prior myocardial infarction, prior stroke, or symptomatic peripheral arterial disease)
- Must be on medical therapy for cardiovascular disease (e.g. lipid-lowering medication, platelet-aggregation inhibitors, beta-blockers, ACE inhibitors, ARBs).
- Must be used in combination with a reduced calorie diet and increased physical activity.
- **Initial Duration of Approval:** 6 months
- **Reauthorization Criteria:**
  - Must be on medical therapy for cardiovascular disease (e.g. lipid-lowering medication, platelet-aggregation inhibitors, beta-blockers, ACE inhibitors, ARBs).
  - Must be used in combination with a reduced calorie diet and increased physical activity
- **Reauthorization Duration of Approval:** 12 months

Coverage of a glucagon-like peptide (GLP-1) receptor agonist to **treat moderate to severe obstructive sleep apnea (OSA)** may be provided when the following criteria are met:

- Must be 18 years of age or older
- Must have a BMI $\geq$ 30 kg/m^2
- Must have baseline polysomnography confirming disease severity with an apnea-hypopnea index (AHI) $\geq$ 15 events/hour without use of positive airway pressure (PAP)
- Must have tried dietary modifications for weight loss
- Must be used in combination with a reduced calorie diet and increased physical activity.
- **Initial Duration of Approval:** 12 months
- **Reauthorization Criteria:**
  - Must meet ONE of the following:
    - Must have and maintain at least a 25% reduction in AHI compared to baseline as documented via either sleep study or device report
    - Must have and maintain at least a 5% weight reduction compared to baseline
  - Must be used in combination with a reduced calorie diet and increased physical activity.
- **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.

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OBESITY TREATMENT 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 8:00 am to 7:00 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

For age < 18 years old, what is the BMI percentile for age and sex? _____ %

For Weight Loss, which of the following co-morbid conditions is present, if any:

☐ Diabetes ☐ Obstructive sleep apnea (OSA) ☐ Hypertension ☐ Coronary artery disease ☐ Hyperlipidemia
☐ Cardiovascular disease (i.e. prior MI, prior stroke, symptomatic PAD)

For reduction of risk of MACE, is the member being treated for cardiovascular disease? ☐ Yes (list the med(s) below) ☐ No

For treatment of Obstructive Sleep Apnea (OSA), what is baseline AHI (without PAP)? ☐ < 15 events/hour ☐ ≥ 15 events/hour

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

Is the member continuing to include diet and exercise? ☐ Yes ☐ No

For weight loss, provide the following:

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

For cardiovascular disease, is the member taking medication for the cardiovascular disease? ☐ Yes ☐ No

For treatment of OSA: Baseline AHI: _____ events/hr, date: _____ Current AHI: _____events/hr, date: _____

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date