Updated: 11/2018
DMMA Approved: 12/2018

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

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

Weight Gain Promoting Agents Prior Authorization Criteria:

For all requests for Megace (megestrol) all of the following criteria is met:

Coverage may be provided with a diagnosis of anorexia, cachexia, or an unexplained, significant weight loss in patients with a diagnosis of acquired immunodeficiency syndrome (AIDS); Breast cancer, palliative treatment of advanced disease (recurrent, inoperable, or metastatic); Endometrial carcinoma, palliative treatment of advanced disease (recurrent, inoperable, or metastatic, and the following criteria is met:

- Member is using medication for the treatment of nausea/vomiting and there is documentation of trial and failure to respond adequately to a preferred conventional antiemetic treatment (e.g. ondansetron).
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- **Initial Duration of Approval:** 12 months
- **Reauthorization**:
    - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment
    - **Reauthorization Duration of Approval**: 12 months

For all requests for Oxandrin (oxandrolone) all of the following criteria is met:

Coverage may be provided with a diagnosis of adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who without definite pathophysiologic reasons fail to gain or to maintain normal weight, to offset the protein catabolism associated with prolonged administration of corticosteroids, and for the relief of the bone pain frequently accompanying osteoporosis, and the following criteria is met:

- Member is using medication for the treatment of nausea/vomiting and there is documentation of trial and failure to respond adequately to a preferred conventional antiemetic treatment (e.g. ondansetron).
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- **Initial Duration of Approval:** 12 months
- **Reauthorization**:
    - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment

- **Reauthorization Duration of Approval**: 12 months

For all request for Marinol (dronabinol) all of the following criteria is met:

Coverage may be provided with a diagnosis of anorexia associated with weight loss in patients with AIDS; Nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments, and the following criteria is met:

- Member is using medication for the treatment of nausea/vomiting and there is documentation of trial and failure to respond adequately to a preferred conventional antiemetic treatment (e.g. ondansetron).
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- **Initial Duration of Approval:** 12 months
- **Reauthorization**:
  - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment
- **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.

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Weight Gain Promoting 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) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
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 (if medically please provide a 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)

Is the member within the FDA-approved age range for the product requested? ☐ Yes ☐ No

Is the requested drug being prescribed for an FDA-approved indication? ☐ Yes ☐ No

Has the member tried and failed a preferred conventional antiemetic treatment? ☐ Yes ☐ No

Is the dose prescribed consistent with the FDA-approved package labeling for the diagnosis? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date