Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Obesity Treatment Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Obesity Treatment Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Obesity Treatment Agent. See the Preferred Drug List (PDL) for the list of preferred Obesity Treatment Agents at: https://papdl.com/preferred-drug-list.

2. A stimulant Obesity Treatment Agent when there is a record of a recent paid claim for another stimulant Obesity Treatment Agents in the point-of-sale on-line claims adjudication system (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Obesity Treatment Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a request for a drug containing a glucagon-like peptide-1 (GLP-1) receptor agonist, see the GLP-1 Receptor Agonists policy;

   NOTE: GLP-1 Receptor Agonists are not covered for the treatment of overweight or obesity. GLP-1 Receptor Agonists are covered for the treatment of diagnoses that are indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or other medically accepted indications excluding treatment of overweight or obesity.

   OR

2. For a request for Evekeo or any other Obesity Treatment Agent containing amphetamine for any indication other than the treatment of obesity, see Stimulants and Related Agents policy; **OR**

3. **One** of the following:

   a. For beneficiaries 18 years of age and older, **one** of the following:

      i. Has a body mass index (BMI) greater than or equal to 30 kg/m^2

      ii. **Both** of the following:

         a) **One** of the following:

            (i) Has a BMI greater than or equal to 27 kg/m^2 and less than 30 kg/m^2
            (ii) Has been determined by the prescriber to be a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for the beneficiary's ethnicity, etc.

b) Has at least **one** weight-related comorbidity as determined by the prescriber, such as dyslipidemia, hypertension, type 2 diabetes, prediabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.

b. For beneficiaries less than 18 years of age, has a BMI in the 95th percentile or greater standardized for age and sex based on current Centers for Disease Control and Prevention charts;

AND

4. Has been counseled about lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity); **AND**

5. Is age- and weight-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

6. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

7. Does not have a contraindication to the prescribed drug; **AND**

8. For Evekeo or any other Obesity Treatment Agent containing amphetamine, **all** of the following:

   a. Was assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescribing provider,

   b. Has documentation that the beneficiary has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction,

   c. For a beneficiary with a history of comorbid substance dependency, abuse, or diversion, has results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances,

   d. **Both** of the following:

      i. Has a history of trial and failure of or a contraindication or an intolerance to all other Obesity Treatment Agents (preferred and non-preferred)
      ii. Has documentation from the prescriber explaining the rationale for why the requested drug is needed and a plan for tapering;

   AND

9. For all other non-preferred Obesity Treatment Agents, has history of therapeutic failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication; **AND**

10. For therapeutic duplication of a stimulant Obesity Treatment Agent, **one** of the following:

a. Is being titrated to or tapered from another stimulant Obesity Treatment Agent
b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR OBESITY TREATMENT AGENTS: The determination of medical necessity of a request for renewal of a prior authorization for an Obesity Treatment Agent that was previously approved will take into account whether the beneficiary:

1. **One** of the following:

   a. **One** of the following:

      i. For beneficiaries 18 years of age and older, experienced a percent reduction of baseline body weight that is consistent with the recommended cutoff in FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after three months of therapy with the maximum recommended/tolerated dose
      ii. For beneficiaries less than 18 years of age, experienced a percent reduction of baseline BMI or BMI z-score that is consistent with the recommended cutoff in FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after three months of therapy with the maximum recommended/tolerated dose,

   b. Experienced improvement in degree of adiposity or waist circumference from baseline,

   c. Experienced clinical benefit from the Obesity Treatment Agent in at least **one** weight-related comorbidity from baseline as determined by the prescriber, such as dyslipidemia, hypertension, type 2 diabetes, prediabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc;

   AND

2. Has been counseled about lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity); **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Does not have a contraindication to the prescribed drug; **AND**

5. For Evekeo or any other Obesity Treatment Agent containing amphetamine, **both** of the following:

a. For a beneficiary with a history of comorbid substance dependency, abuse, or diversion, has results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances
b. Has documentation from the prescriber explaining the rationale for why the requested drug continues to be needed and plan for tapering;

AND

6. For all other non-preferred Obesity Treatment Agents, has history of therapeutic failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication; **AND**

7. For therapeutic duplication of a stimulant Obesity Treatment Agent, **one** of the following:

a. Is being titrated to or tapered from another stimulant Obesity Treatment Agent
b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Obesity Treatment Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

C. Dose and Duration of Therapy

Requests for prior authorization of Obesity Treatment Agents will be approved as follows:

1. For Evekeo or any other Obesity Treatment Agent containing amphetamine, all requests will be approved for up to three months.

2. For all other Obesity Treatment Agents:

a. Initial requests for prior authorization will be approved for up to four months.
b. Renewals of requests for prior authorization will be approved for up to six months.

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OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/1/2026)*

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested***: ****NOTE**: Requests for drugs containing a GLP-1 receptor agonist should use the GLP-1 Receptor Agonists fax form. GLP-1 receptor agonists are not covered for the treatment of overweight or obesity.*	Strength:	Dosage form:
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
Does the beneficiary have any contraindications to the requested drug?	☐Yes ☐No	*Submit documentation.*
ATTESTATION from the prescriber: Was beneficiary recently counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity?	☐Yes	☐No

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. The beneficiary is 18 years of age or older and:

Pre-treatment weight: _____ Pre-treatment BMI: _____

☐Has a BMI greater than or equal to 30 kg/m^2

☐Has a BMI greater than or equal 27 kg/m^2 and less than 30 kg/m^2 AND at least one of the following weight-related comorbidities:

- ☐cardiovascular disease
- ☐dyslipidemia
- ☐hypertension
- ☐metabolic syndrome
- ☐obstructive sleep apnea
- ☐prediabetes
- ☐type 2 diabetes
- ☐other (list): _____

☐Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for beneficiary's ethnicity, etc. AND has at least one of the following weight-related comorbidities:

- ☐cardiovascular disease
- ☐dyslipidemia
- ☐hypertension
- ☐metabolic syndrome
- ☐obstructive sleep apnea
- ☐prediabetes
- ☐type 2 diabetes
- ☐other (list): _____

2. The beneficiary is less than 18 years of age and:

Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

☐Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

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3. **Request is for EVEKEO (amphetamine) or any other Obesity Treatment Agent that contains amphetamine:**
   - ☐ Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history
   - ☐ Was educated regarding the potential adverse effects of stimulants, including the risk of misuse, abuse, and addiction
   - ☐ Has a history of trial and failure of or a contraindication or an intolerance to all other Obesity Treatment Agents (preferred and non-preferred)
   - ☐ Has prescriber documentation explaining why the requested drug is needed and a plan for tapering
   - ☐ **For a beneficiary with a history of substance dependency, abuse, or diversion:**
     - ☐ Has results of a recent UDS for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

4. **Request is for ANY OTHER NON-PREFERRED Obesity Treatment Agent (ie, NOT Evekeo [amphetamine] or any other Obesity Treatment Agent that contains amphetamine)** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*:
   - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication

RENEWAL requests

1. **For a beneficiary is 18 years of age or older:**

   Pre-treatment weight: _____ Current weight: _____

2. **For a beneficiary is less than 18 years of age:**

   Pre-treatment BMI: _____ Current BMI: _____

   Pre-treatment BMI z-score: _____ Current BMI z-score: _____

3. **All requests:**
   - ☐ The beneficiary experienced a percent reduction in body weight (for beneficiaries 18 years of age or older) or BMI or BMI z-score (for beneficiaries less than 18 years of age) that is consistent with the recommended cutoff in the FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose
   - ☐ The beneficiary experienced an improvement in degree of adiposity or waist circumference from baseline
   - ☐ The beneficiary experienced clinical benefit with the requested drug in at least one weight-related comorbidity from baseline, such as dyslipidemia, hypertension, type 2 diabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.

4. **Request is for Evekeo (amphetamine) or any other Obesity Treatment Agent that contains amphetamine:**
   - ☐ Has prescriber documentation explaining why the requested drug is needed and a plan for tapering (*submit documentation)*
   - ☐ **For a beneficiary with a history of substance dependency, abuse, or diversion:**
     - ☐ Has results of a recent UDS for licit & illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

5. **Request is for ANY OTHER NON-PREFERRED Obesity Treatment Agent (ie, NOT Evekeo [amphetamine] or any other Obesity Treatment Agent that contains amphetamine)** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*:
   - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: