

Community Plan 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:	<u> </u>													
PRESCRIBER INFORMATION														
Last Name:	First Name:													
NPI Number:														
Phone Number:	Fax Number:													
DRUG INFORMATION														
For initial requests, continue below. For renewal rec	quests, proceed to page 4 of this form.													
Drug Name:	Drug Form:													
Drug Strength:	Dosing Frequency:													
Length of Therapy:	Quantity:													
Day Supply:														
(Form continued on next page.)														

Member's Last Name: Member's First Name:													
DIAGNOSIS AND MEDICAL INFORMATION		_	.1										
If the physician does not have the necessary information, the request will be denied and the fax form requesting additional information will be sent to the prescriber.													
Coverage for all 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 his cancer or multiple endocrine neoplasia 2 syndrome (if requesting a GLP-1 Recep	•		•	' thyr	roid								
For all others except Imcivree®, additional qualifying criteria are:													
Participation in nutritional counseling; AND													
Participation in 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. for high-morbidity conditions):	, puts t	he pa	itient	at ri	sk								
☐ Yes ☐ No													
The written documentation must include the following:													
Current medical status and weight-loss plan. 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													
Current accurate height and weight measurements													
Summarize details of previous weight-loss treatment plans to include diet and exe submitting a copy of the plan:	rcise pl	ans, i	n add	litior	1 to								
Assessment:													

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(Form continued on next page.)

Member's Last Name:							Member's First Name:															
Ot	her Dia	gnoses	/Risk F	acto	rs:		<u> </u>					l		l			l		l	l		
DR	RUG SP	ECIFIC	CRITE	RIA	(Mini	mun	n ag	es a	re po	er F	DA :	appr	ova	ls)								
	For ph psule (r		-						azin	e ta	blet	(min	age	18),	phe	ndim	etra	zine	ER			
	Th	e mem	ber ha	s a Bi	MI of	≥ 30	kg/n	n²; O	R													
		ne mem e, dysli					-						_		ated	com	orbid	ity (i	.e. co	orona	ary h	eart
2.	For be	nzphet	amine	(mir	n age	17),	dieth	nylpr	opio	n (ı	min a	age 1	6):									
	Th	e mem	ber ha	s a BI	MI of	≥ 30	kg/n	n²														
3.	For Im	civree) (min	age 6	5):																	
	ВІ	MI ≥ 30	kg/m²	² ; AN	D																	
	☐ Pr	rescribe	ed by o	r in c	consul	tatio	n wi	th ar	enc	locr	inol	ogist	or ge	eneti	cist;	AND)					
	Шм	lember	has Ba	ardet	-Biedl	sync	drom	ne (Bl	BS); (OR												
		lember ptin re	•	•				•	•	-	•					tilisi	n/ke	xin t	ype 1	L (PC	SK1),	or
		lember gnificar			ariant	s are	inte	erpre	ted a	as p	atho	geni	c, lik	ely p	atho	genio	c, or	of un	certa	ain		
4. 18)	For GL):	.P-1 rec	eptor	agon	ists ir	ndica	ted	for w	eigh	it lo	ss (\	Vego	vy/S	Saxeı	nda r	nin a	ge 1	2, Ze	pbou	ınd n	nin a	ge
		BMI:	> 40 kg	g/m²,	if no	appli	cabl	e risk	c fact	tors	; OR											
		BMI:	> 37 kg	g/m ²	with c	one o	r mo	ore o	f the	fol	lowi	ng ris	k fac	ctors	dys	lipide	emia,	, hyp	erter	nsion	, typ	е
	2 dial	betes; A	AND																			
		Mem	ber ha	ıs trie	ed and	d faile	ed o	ne of	the	nor	า-GLI	P1 w	eight	-loss	med	dicat	ions*	; OR				
		Mem	ber is	intol	erant	to al	l nor	n-GLF)1 w	eigh	nt-los	ss me	dica	tions	*; A l	ND						
		Mem	ber no	t cor	ncurre	ently	on a	noth	er G	LP-í	1 rec	epto	r ago	nists	; AN	D						
		The r	nembe	er has	s triec	d and	faile	ed* t	he se	elec	ted	orod	uct a	s inc	icate	ed or	the	PDL:	http	s://		
	\\\\\\\	virgini	amedio	raidn	harm	acvse	rvic	ود در	m/n	rov	ider	/nref	erre	d-dri	ισ-lis	t/						

(Form continued on next page.)

Member's Last Name:										ſ	Member's First Name:													
*[Defini	itions	of Ac	cepte	d Dru	ıg Tri	ial																	
Dı	Drug											Trial												
Benzphetamine, diethylpropion, phendimetrazine, phentermine												3 month trial without a weight loss of 10lbs												
Orlistat												6 month trial without a weight loss of 10lbs												
GI	LP-1 F	Recep	otor A	gonist	·							6 m	onth	tria	l with	nout	a bo	dy w	eight	t redi	uctio	n of !	5%	
LEI	NGTH	l OF	AUTH	IORIZ	ATIC	N																		
	Initia	al Re	quest:	Varie	s (dr	ug sp	ecif	ic)																
•	Benz	zphet	amine	e, diet	hylpr	opio	n, pł	nend	imet	razin	e, p	hent	term	ine -	- 3 m	onth	ıS							
•	GLP-	·1 red	eptor	agoni	ists –	6 m	onth	S																
•	Orlis	tat –	6 mo	nths																				
•	Imci	vree	[®] – 4 n	nonth	S																			
req			Reque s belo					o lor	nger l	be gr	rant	ted o	nce	a me	embe	er rea	che	s a Bi	MI <	25. S	ee a	dditi	onal	
•	• Benzphetamine, diethylpropion, phendimetrazine, phentermine – 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-lb. 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 \geq 5% reduction in body weight (or \geq 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.																							
	Chec	ck if a	ıdditio	nal do	ocum	ents	will	be u _l	pload	ded														
(1	(Form continued on next page.)																							

Member's Last Name:	Member's First Name:										
All approvals are subject to the criteria on this form	n. Existing authorizations will be honored until renewal										
Prescriber Signature (Required) By signature, the physician confirms the above informand verifiable by member records.	Date nation is accurate										
Please include ALL requested information. Incomplet Submission of documentation does NOT guarantee cov	•										

Services. Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826