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: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

All weight-loss medications will require a SA, which include, but are not limited to, the following: *Covered only for members 16 years of age or older unless otherwise specified*

- ☐ Adipex-P®/Suprenza™ (phentermine)
- ☐ Alli®/Xenical® (orlistat)
- ☐ Bontril®/Bontril PDM® (phendimetrazine)
- ☐ Contrave® (bupropion SR/naltrexone SR)
- ☐ Didrex®/Regimex® (benzphetamine)
- ☐ Imcivree® (setmelanotide) **ages 6 and older*
- ☐ Radtue® (diethylpropion)
- ☐ Saxenda® (liraglutide) **ages 12 and older*
- ☐ Wegovy® (semaglutide) **ages 12 and older*

Drug Name: _____ **Drug Form:** _____

Drug Strength: _____ **Dosing Frequency:** _____

Length of Therapy: _____ **Quantity:** _____

Day Supply: _____

(Form continued on next page.)

 Revised: 06/08/2023 | Effective: XX/XX/2023

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

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 these medications will be limited to the following:

1. **Absence of medical contraindications:**

   ☐ No contraindications to use; **AND**

   ☐ No malabsorption syndromes, cholestasis, pregnancy, and/or lactation; **AND**

   ☐ No history of an eating disorder (e.g., anorexia, bulimia)

2. **Additional qualifying criteria to include (excluding Imcivree®) the following:**

   ☐ Participation in nutritional counseling; **AND**

   ☐ Participation in physical activity program, unless medically contraindicated; **AND**

   ☐ Commitment to continue the above weight-loss treatment plan.

3. **Additional criteria for Imcivree® ONLY:**

   ☐ Prescribed by or in consultation with an endocrinologist or geneticist**; AND**

   ☐ Member has proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test**; AND**

   ☐ Member's genetic variants are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS).

4. **The provider attests that the patient's obesity is disabling and life threatening (i.e., puts the patient at risk for high-morbidity conditions):**

   ☐ Yes ☐ No

5. BMI meeting the following criteria (for Initial Request only):

   - **Adipex-P®/Suprenza™, Bontril®/Bontril PDM®, Didrex®/Regimex®, Alli®/Xenical®, Contrave®, Radtue®**:

     ☐ BMI ≥ 27 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes; **OR**

     ☐ BMI ≥ 30, if no applicable risk factors

(Form continued on next page.)

Member's Last Name:

Member's First Name:

- **Wegovy®, Saxenda®**:
  - ☐ BMI ≥ 35 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes; **OR**
  - ☐ BMI ≥ 40, if no applicable risk factors; **AND**
  - ☐ Have tried and failed one of the non-GLP1 weight-loss medications 6 months prior to request.
  - ☐ For patients 12–18 years of age, a BMI that is ≥ 140% of the 95th percentile by age and sex
  - ☐ For patients 12–18 years of age, an initial BMI that is ≥ 120% of the 95th percentile by age and sex with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes.
- **Imcivree®**:
  - ☐ BMI ≥ 30 or ≥ 95th percentile on pediatric growth chart

6. The written documentation must include the following:
   - ☐ Current medical status and weight loss plan, to include nutritional or dietetic assessment by a registered dietician and exercise evaluation and plan
   - ☐ Current accurate height and weight measurements
   - ☐ No medical contraindications to use a reversible lipase inhibitor (**Xenical®**)
   - ☐ If applicable, which non-GLP-1 weight-loss drugs the patient has tried and failed; description of the reason for failure; trial less than 30-day trial and clinical intolerance may be subject to denial (**Saxenda® and Wegovy®**)
   - ☐ No chronic opioid use concurrently with **Contrave®**
   - ☐ Member not concurrently on Victoza® or Ozempic® or other GLP-1 inhibitors (**Saxenda® and Wegovy®**)

(Form continued on next page.)

Member's Last Name:

Member's First Name:

Length of Authorization:

☐ **Initial Request: Varies (drug specific)**

- Benzphetamine, diethylpropion, phendimetrazine, phentermine, Contrave® – 3 months
- Wegovy® – 6 months
- Alli®/Xenical® – 6 months
- Saxenda® and Imcivree® – 4 months

☐ **Renewal Request: See additional requirements below (drug specific)**

- **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).
- **Long-term use is still being clinically evaluated. At this time, authorizations over one year are subject to initial criteria.**
- **Alli®/Xenical®** – 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).
- **Contrave®** – Approve for 6 months with each renewal if weight reduction continues.
- **Saxenda®** – If the member achieves a weight loss of at least 4% of baseline weight, an additional 6-month SA may be granted as long as weight reduction continues.
- **Imcivree®** – If the member has experienced ≥ 5% reduction in body weight (or ≥ 5% of baseline BMI in those with continued growth potential), an additional 1 year SA may be granted.
- **Wegovy®** – If the member achieves a weight loss of at least 5% of baseline weight, an additional 6 month SA may be granted.

(Form continued on next page.)

Member's Last Name:

Member's First Name:

7. **Assessment**:

8. **Other Diagnoses/Risk Factors**:

9. **Current BMI (Adult) or % of 95th percentile weight (12–18 y.o.):** _____

10. **Pre-treatment BMI (Adult) or % of 95th percentile weight (12–18 y.o.):** _____

11. **Summarize details of previous weight-loss treatment plans to include diet and exercise plans, in addition to submitting a copy of the plan consistent with Question 6:**

_____ _____

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:

Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street
Glen Allen, VA 23060