AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Group Specific Benefit

Drug Requested: Weight Management Drugs (select one of the following)

❑ **benzphetamine 50 mg**	❑ **Qsymia®** (phentermine/topiramate ER)
❑ **Contrave®** (naltrexone HCl/bupropion HCl)	❑ **Saxenda®** (liraglutide)
❑ **diethylpropion IR/ER**	❑ **Wegovy®** (semaglutide)
❑ **Lomaira™** (phentermine hydrochloride USP)	❑ **Xenical®** (orlistat)
❑ **phendimetrazine IR**	❑ **Zepbound™** (tirzepatide)
❑ **phentermine HCL**	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

(Continued on next page)

- Will the member be discontinuing a previously prescribed weight loss medication if approved for requested medication?

❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

Provider please note: If member was previously approved for the requested medication under an alternate health plan, please complete the reauthorization section of the PA form.

❑ Member must meet **ONE** of the following age requirements:
- ❑ 18 years of age or older
- ❑ Qsymia® only: 12 years of age or older with an initial body mass index (BMI) in the 95th percentile or greater standardized for age and sex
- ❑ Wegovy® only: 12 years of age or older with an initial body mass index (BMI) in the 95th percentile or greater standardized for age and sex
- ❑ Saxenda® only: 12 years of age or older **AND** has a measured body weight of at least 60 kg (132 lbs)

❑ If requesting Saxenda®, Wegovy® or Zepbound™, member is **NOT** using concurrent therapy with another GLP-1 receptor agonist prescribed for another indication (e.g., Mounjaro®, Ozempic®, Trulicity®, Rybelsus®)

❑ Member must have participated in a weight loss treatment plan (i.e. nutritional counseling, an exercise regimen and/or a calorie/fat-restricted diet) in the past 6 months and will continue to follow this treatment plan while taking an anti-obesity medication

❑ Provider must submit current height and weight measurements **(verified by chart notes)**

Height: _____ **Current Weight:** _____ **BMI:** _____ **Date:** _____

❑ Member must meet **ONE** of the following BMI requirements:
- ❑ BMI of 30 or greater
- ❑ BMI of 27 or greater with co-morbid conditions that may include coronary artery disease, hypertension, congestive heart failure, diabetes, dyslipidemia, or sleep apnea

Comorbid Condition(s): _____ **(verified by chart notes)**

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Reauthorization: up to 12 months

(Contingent upon member continuing to lose weight up to desired BMI; PA requests for anti-obesity drugs will not be renewed if a member's BMI is below 18.5)

Baseline measurements: (Baseline is defined as body measurements obtained prior to the start of the requested medication)

Height: _____ **Current Weight:** _____ **BMI:** _____ **Date:** _____

Current measurements: (verified by chart notes)

Height: _____ **Current Weight:** _____ **BMI:** _____ **Date:** _____

All of the following reauthorization criteria must be met:

- ❑ Member must continue with weight loss treatment plan (i.e., nutritional counseling, an exercise regimen and/or a calorie/fat-restricted diet) while on medication for weight reduction
- ❑ Member must meet **ONE** of the following:
  - ❑ Member has achieved at least a 5% decrease in their weight within the initial approval period of 6 months as documented by their physician (Initial renewal length = 6 months)
  - ❑ Member has maintained initial 5% weight loss (Subsequent renewal length = 12 months)
- ❑ Member is compliant with requested medication **(verified by pharmacy claims)**
- ❑ Provider attests that member has **NOT** developed any negative side effects from requested medication
- ❑ Provider attests that member does **NOT** have any medical or drug contraindications to therapy with requested medication

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by the Pharmacy and Therapeutics Committee**: ~~9/17/2009;~~ **2/16/2023**
REVISED/UPDATED/REFORMATTED: ~~10/6/2014; 10/8/2014; 11/6/2014; 11/20/2014; 1/26/2015; 5/22/2015; 12/29/2015; 11/17/2016; 12/31/2016; 2/8/2017; 3/28/2017; 8/20/2017; 3/7/2018; 6/18/2019; 9/10/2020; 12/31/2020; 4/2/2021; 9/9/2021; 3/7/2022; 4/12/2022; 6/15/2022; 6/16/2022; 8/19/2022; 10/21/2022; 11/11/2022;;03/03/2023 10/26/2023, 2/9/2024; 4/24/2024;~~ **07/03/24**