**MOLINA HEALTHCARE**
**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**: _____

## PRESCRIBER INFORMATION

**Last Name:**

**First Name:**

**NPI Number:**

**Phone Number:** ___ – ___ – ____

**Fax Number:** ___ – ___ – ____

## DRUG INFORMATION

**For initial requests, continue below. For renewal requests, 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.)*





Revised: 08212024 | Effective: 09302024

**Member's Last Name:**

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**Member's First Name:**

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## 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 (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 history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome (if requesting a GLP-1 Receptor Agonists)
2. **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.
3. **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

**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 exercise plans, in addition to submitting a copy of the plan:**

**Assessment:**

**Member's Last Name:**

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**Member's First Name:**

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**Other Diagnoses/Risk Factors:**

## DRUG SPECIFIC CRITERIA

1. **For phentermine (min age 17), phendimetrazine tablet (min age 18), phendimetrazine ER capsule (min age 17) and orlistat (min age 12)::**

   ☐ The member has a BMI of ≥ 30 kg/$m^2$; **OR**

   ☐ The member has a BMI of ≥ 27 kg/m2 with at least one weight-related comorbidity (i.e. coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes)

2. **For benzphetamine (min age 17), diethylpropion (min age 16)::**

   ☐ The member has a BMI of ≥ 30 kg/$m^2$

3. **For Imcivree® (min age 6):**

   ☐ The member has a BMI of ≥ 30 kg/$m^2$; **AND**

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

   ☐ Member has Bardet-Biedl syndrome (BBS); **OR**

   ☐ 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).

*(Form continued on next page.)*

**Member's Last Name:**

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**Member's First Name:**

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**4. For GLP-1 receptor agonists indicated for weight loss (Wegovy/Saxenda min age 12, Zepbound min age18):**

☐ Member meets one of the following:

- BMI > 40 kg/m$^2$, if no applicable risk factors; **OR**
- BMI > 37 kg/m$^2$ with one or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes

**AND**

☐ Member has tried and failed one of the non-GLP1 weight-loss medications* or member is intolerant to all non-GLP1 weight-loss medications*; AND

☐ Member not concurrently on another GLP-1 receptor agonists

☐ If for an FDA-indicated GLP-1 receptor agonist, the member has tried and failed* the selected product as indicated on the PDL at: https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list/

***Definitions of Accepted Drug Trial**

| 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 |
| GLP-1 Receptor Agonist | 6 month trial without a body weight reduction of 5% |

## LENGTH OF AUTHORIZATION

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

- Benzphetamine, diethylpropion, phendimetrazine, phentermine – 3 months
- GLP-1 agonists – 6 months
- Orlistat – 6 months
- Imcivree® – 4 months

☐ **Renewal Request: Renewals will no longer be granted once a member reaches a BMI < 25.**

**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).
- **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 ≥ 5% reduction in body weight (or ≥ 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 weightcompared to the most recent authorization, an additional 6-month SA may be granted.

☐ Check if additional document

**All approvals are subject to the criteria on this form. Existing authorizations will be honored until renewal.**

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| **Prescriber Signature (Required)**<br>By signature, the physician confirms the above information is accurate and verifiable by member records. | **Date** |

**Please include ALL requested information. Incomplete forms will delay the SA process.**
Submission of documentation does NOT guarantee coverage by Molina Healthcare. The completed form may be: **FAXED TO** (844) 278-5731, or you may call (800) 424-4518 (TTY: 711)