OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pgs: _____	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:	
Strength & package size/quantity/refills:	
Additional strengths/quantity for each/refills for each to allow for dose titration:	
Directions:	
Diagnosis (*submit documentation*):	DX code (*required*):
Does the beneficiary have any contraindications to the requested medication?	☐ 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/m2

☐ Has a BMI greater than or equal 27 kg/m2 and less than 30 kg/m2 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

3. Request is for EVEKEO (amphetamine) ODT/tablet:

☐ 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)
List medications tried: _____

☐ Has prescriber documentation explaining why Evekeo (amphetamine) 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

INITIAL REQUESTS (continued)

4. Request is for a PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST (e.g., Saxenda, Wegovy, Zepbound)
*(Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred drugs in this class.):*

- ☐ Has a concurrent diagnosis of diabetes mellitus OR has taken an antidiabetic drug in the last 120 days and:
  - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist:
    - ☐ Ozempic
    - ☐ Trulicity
    - ☐ Victoza
- ☐ Does NOT have diabetes mellitus and has NOT taken an antidiabetic drug in the past 120 days

5. Request is for a NON-PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST *(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 containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Saxenda
  - ☐ Wegovy
  - ☐ Zepbound
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Ozempic
  - ☐ Trulicity
  - ☐ Victoza

6. Request is for ANY OTHER NON-PREFERRED Obesity Treatment Agent (i.e., NOT Evekeo [amphetamine] or a drug containing a GLP-1 receptor agonist)
(*Refer to **https://papdl.com/preferred-drug-list f**or 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:
  - ☐ phentermine capsule or tablet
  - ☐ Saxenda
  - ☐ Wegovy
  - ☐ Zepbound

RENEWAL REQUESTS

1. For a beneficiary 18 years of age or older:
Pre-treatment weight: _____ Current weight: _____

2. For a beneficiary less than 18 years of age:
Pre-treatment BMI: _____ Current BMI: _____
Pre-treatment BMI z-score: _____ Current BMI z-score: _____

3. All requests:

- ☐ The dose of the requested medication is currently being titrated
- ☐ 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 medication 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) ODT/tablet:

- ☐ Has prescriber documentation explaining why Evekeo (amphetamine) 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 a NON-PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST *(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 containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Saxenda
  - ☐ Wegovy
  - ☐ Zepbound
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
  - ☐ Ozempic
  - ☐ Trulicity
  - ☐ Victoza

RENEWAL REQUESTS (continued)

6. Request is for <u>ANY OTHER NON-PREFERRED Obesity Treatment</u> Agent (i.e., NOT Evekeo [amphetamine] or a drug containing a GLP-1 receptor agonist)

*(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:

☐ phentermine capsule or tablet
☐ Saxenda
☐ Wegovy
☐ Zepbound

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: