AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – GLP-1s for Weight Management

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

7. Requester Contact Information: _____

Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity per 30 days: _____

11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days __Other:_____

Clinical Information *****Submit medical records to support all responses below.*****

For initial requests (Wegovy, Saxenda, and Zepbound):

1. Please list the beneficiary's baseline weight and BMI. Weight_____ Date_____ BMI_____ Date_____
2. Is the beneficiary 18 years or age or older? Yes___ No___
   - 2a. Does the beneficiary have a BMI greater than or equal to 30 kg/m^2? Yes___ No___
   - 2b. Does the beneficiary have a BMI greater than or equal to 27 kg/m^2? Yes___ No___
     - 2b-i. Does the beneficiary have at least one weight-related comorbidity/risk factor/complication (i.e., hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? Yes___ No___
       Please list: _____
3. Is the beneficiary between 12-17 years of age? Yes___ No___
   - 3a. Does the beneficiary have a BMI greater than or equal to the 95th percentile for age and sex? Yes___ No___
   - 3b. Does the beneficiary have a BMI greater than or equal to 30 kg/m^2? Yes___ No___
   - 3c. Does the beneficiary have a BMI greater than or equal to the 85th percentile for age and sex? Yes___ No___
     - 3c-i. Does the beneficiary have at least one weight-related comorbidity/risk factor/complication (i.e., hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? Yes___ No___
       Please list: _____
4. Is the beneficiary 45 years of age or older? Yes___ No___
   - 4a. Does the beneficiary have a BMI greater than or equal to 27 kg/m^2? Yes___ No___
     - 4a-i. Does the beneficiary have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral disease? Yes___ No___
       Please list: _____
5. Is the beneficiary currently on and will the beneficiary continue lifestyle modification including structured nutrition and physical activity, unless physical activity is not clinically appropriate at the time GLP1 therapy commences? Yes___ No___
6. Will the beneficiary be using the requested agent with another GLP-1? Yes___ No___
7. Does the beneficiary have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? Yes___ No___

Continuation Requests (Wegovy, Saxenda, and Zepbound):

8. Has the beneficiary previously been approved for the requested agent through NC Medicaid's PA process? Yes___ No___
9. Beneficiary's baseline and current weight. Baseline Weight_____ Date_____ Current Weight_____ Date_____
10. Beneficiary's baseline and current BMI. Baseline BMI_____ Date_____ Current BMI_____ Date_____
11. Is the beneficiary continuing a current weight loss course of therapy? Yes___ No___
12. **Ages 18 and older –** Has the beneficiary lost a total of 5% of pretreatment weight and is maintaining the 5% weight loss? Yes___ No___
    Baseline Weight_____ Current Weight_____
13. **Ages ≥ 12 to <18 years –** Has the beneficiary had >4% reduction in baseline BMI and is maintaining the weight loss? Yes___ No___
    Baseline Weight_____ Current Weight_____
14. Does the beneficiary have a documented weight loss that is deemed to be a significant reduction from BMI per the prescriber and the weight loss is maintained, yet the 5% (for adults) and 4% (for adolescents) is not met? Yes___ No___

Rationale: _____

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – GLP-1s for Weight Management

15. Is the beneficiary currently on and will continue lifestyle modification including structured nutrition and physical activity?
Yes___ No___

16. Will the beneficiary be using the requested agent with another GLP-1? Yes___ No___

17. Does the beneficiary have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? Yes___ No___

Requests for Non-Preferred Drugs (Saxenda, and Zepbound):

1. __ Failed preferred drugs. List preferred drugs failed: _____
1a. __ Allergic Reaction 1b. __ Drug-to-drug Interaction Please describe reaction: _____
2. __ Previous episode of unacceptable side effect or therapeutic failure. Please provide clinical information: _____
_____
3. __ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____
4. __ Age specific indications. Please give patient age and explain: _____
5. __ Unique clinical indication supported by FDA approval or peer reviewed literature.
Please explain and provide a general reference: _____
6. __ Unacceptable clinical risk associated with therapeutic change. Please explain: _____
_____

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406