

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	☐ phentermine/topiramate ER (Qsymia®)
☐ 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 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: 7 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
 - ☐ phentermine/topiramate ER (generic 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)
- ☐ 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.****