

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)

<input type="checkbox"/> benzphetamine 50 mg	<input type="checkbox"/> Qsymia[®] (phentermine/topiramate ER)
<input type="checkbox"/> Contrave[®] (naltrexone HCl/bupropion HCl)	<input type="checkbox"/> Saxenda[®] (liraglutide)
<input type="checkbox"/> diethylpropion IR/ER	<input type="checkbox"/> Wegovy[®] (semaglutide)
<input type="checkbox"/> Lomaira[™] (phentermine hydrochloride USP)	<input type="checkbox"/> Xenical[®] (orlistat)
<input type="checkbox"/> phendimetrazine IR	<input type="checkbox"/> Zepbound[™] (tirzepatide)
<input type="checkbox"/> 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: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ 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.

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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)**

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

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- ❑ 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.