OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: (*check applicable box below*) *Anti-Obesity/Weight Management* (*Non-Preferred*)

❑ **Adipex-P®** (phentermine HCl)	❑ **Alli® / Xenical®** (orlistat)
❑ **Belviq®/BelviqXR®** (lorcaserin/HCI)	❑ **Bontril®** / **Bontril PDM®** (phendimetrazine)
❑ **Contrave®** (naltrexone HCI/bupropion HCI)	❑ **Didrex®** / Regimex® (benzphetamine)
❑ **Qsymia®** (phentermine/topiramate ER)	❑ **Radtue®** (diethylpropion)
❑ **Saxenda®** (liraglutide)	

DRUG INFORMATION:* *Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

CLINICAL CRITERIA*: *At least one of the following criteria MUST be met to qualify. Current height/weight MUST be included. Chart notes/lab results MUST be attached to this request or authorization process will be delayed.

Coverage for these medications will be limited to the following:

1. **BMI requirements:**
   - ❑ Body mass index (BMI) ≥ 30, if no applicable risk factors
   - ❑ Body mass index (BMI) ≥ 27 with two or more of the following risk factors:

❑ coronary heart disease	❑ dyslipidemia	❑ hypertension	❑ sleep apnea	❑ Type II Diabetes

2. **Age restrictions:**
   - ❑ Covered only for members 16 years of age or older (***Exception: Saxenda® only covered for members 18 years or older)***
3. **Initial Request Requirements:**
   - ❑ No contraindications to use
   - ❑ No malabsorption syndromes, cholestasis, pregnancy and/or lactation
   - ❑ Previous failure of a weight loss treatment plan (e.g. nutritional counseling, an exercise regimen and a calorie/fat-restricted diet) in the past 6 months and will continue to follow as part of the total treatment plan
4. **The written documentation must include:**
   - ❑ Current medical status including nutritional or dietetic assessment
   - ❑ Current therapy for all medical condition(s) including obesity, identifying specific treatments including medications
   - ❑ Current accurate height and weight measurements
   - ❑ No medical contraindications to use a reversible lipase inhibitor **(Xenical®)**
   - ❑ Current weight loss plan or program including diet and exercise plan
   - ❑ No chronic opioid use concurrently with **Contrave®**
   - ❑ Patient not concurrently on Victoza® or other GLP-1 inhibitors **(Saxenda®)**
5. **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.**
6. **Length of Authorization:**
   - ❑ **Initial request: Varies (drug specific)**
     - Benzphetamine, diethylpropion, phendimetrazine, phentermine, Belviq®, Qsymia®, Contrave® - 3 months
     - Alli® / Xenical® - 6 months
     - Saxenda® - 4 months

(continued on next page)

- ❑ **Renewal requests: Varies (drug specific)**
  - **Benzphetamine, diethylpropion, phendimetrazine, phentermine** – If member achieves at least a 10-lb weight loss during initial 3 months of therapy, an additional 3-month prior authorization may be granted. Maximum length of continuous drug therapy = 6 months (waiting period of 6 months before next request)
  - **Belviq®** at least 5% of baseline body weight loss during initial 3 months of therapy, an additional 3-month prior authorization may be granted.
  - **Qsymia®** - If member achieves a weight loss of at least 3% of baseline weight, an additional 3-month prior authorization may be granted. For a subsequent renewal, patient must meet a weight loss of at least 5% of baseline weight to qualify for an additional 6-month prior authorization. Maximum length of continuous drug therapy = 12 months (waiting period of 6 months before next request)
  - **Alli®/Xenical®** - If member achieves at least a 10-lb weight loss, an additional 6-month prior authorization may be granted. Maximum length of continuous drug therapy = 24 months (waiting period of 6 months before next request)
  - **Contrave®** - approve for 6 months with each renewal if weight reduction continues
  - **Saxenda®** - If member achieves a weight loss of at least 4% of baseline weight, additional 6-month prior authorization may be granted as long as weight reduction continues
- ❑ **NOTE –** Renewal prior authorization requests will ***NOT*** be authorized if member's BMI is < 24

7. **Assessment:** _____
8. **Other Diagnoses/Risk Factors**: _____
9. **Current medications**: _____
10. **Current body mass index (BMI)**: _____ **Height**: _____ **Current Weight**: _____
11. **Are there any contraindication for this use, malabsorption syndromes, cholestasis, pregnancy and/or lactation?**
    ❑ Yes ❑ No
    If ***YES***, please describe: _____
12. **Document details of previous weight loss treatment plans to include diet and exercise plans. Submit copy of plan.**

Additional Comments: _____

*****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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/27/2017;~~ **12/24/2017**