

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)**

<input type="checkbox"/> Adipex-P® (phentermine HCl)	<input type="checkbox"/> Alli® / Xenical® (orlistat)
<input type="checkbox"/> Belviq®/BelviqXR® (lorcaserin/HCl)	<input type="checkbox"/> Bontril® / Bontril PDM® (phendimetrazine)
<input type="checkbox"/> Contrave® (naltrexone HCl/bupropion HCl)	<input type="checkbox"/> Didrex® / Regimex® (benzphetamine)
<input type="checkbox"/> Qsymia® (phentermine/topiramate ER)	<input type="checkbox"/> Radtue® (diethylpropion)
<input type="checkbox"/> 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:

<input type="checkbox"/> coronary heart disease	<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> hypertension	<input type="checkbox"/> sleep apnea	<input type="checkbox"/> Type II Diabetes
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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.