Disclaimer: All requests for Antiobesity Drugs require prior authorization and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

Coverage may be provided for adults 18 years of age or older who are over-weight or obese when the following criteria is met:

Prior Authorization Criteria:
- The member has tried and failed to achieve adequate weight loss with diet and exercise alone
- The prescribed product will be used as an adjunct to diet and exercise
- The dosing is within the recommended guidelines based on each product's package insert
- Coverage will be provided for patients who:
  - Have a BMI \( \geq 30 \text{ kg/m}^2 \) OR
  - Have a BMI \( \geq 27 \text{ kg/m}^2 \) with at least one of the following comorbidities
    - Hypertension
    - Type 2 diabetes mellitus
    - Dyslipidemia

Contraindications:
- Pregnancy

Coverage for these products will be provided for 90 days for initial requests, with the patient receiving the prescription in 30 day increments. Reauthorization will be approved for 12 months provided the member meets the following criteria:
- Must lose at least 5% of their initial starting weight within the initial approval request (i.e. 90 days) as documented by their physician
- The patient must continue to implement diet and exercise into their weight loss plan
- If the patient fails to maintain at least a 5% reduction from baseline, the request will be denied

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.
References:

**Request for Prior Authorization – Antiobesity Drug**  
Website form: [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)

Submit request via: Fax - 1-855-476-4158

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**Authorization**

**Diagnosis:** ______________________________________________________

**Current Weight (lbs):** _______ **Current Height (inches):** _______ **BMI:** _______

**Comorbid Conditions** (select all that apply):

- [ ] Diabetes Mellitus, Type 2
- [ ] Dyslipidemia
- [ ] Hypertension
- [ ] Other: _______________________________________________________

**Previous weight loss attempts? (diet and exercise):** Yes [ ] No [ ]

**Will the patient continue on this plan or begin a new plan (please explain):** Yes [ ] No [ ]

**Is the patient pregnant?** Yes [ ] No [ ]

**Proposed regimen (Drug, strength, frequency):** ________________________________

**Reauthorization** (only complete if patient has previously taken this medication)

**Has the patient taken this medication before? (if yes answer questions below)** Yes [ ] No [ ]

1) **Weight Prior to Drug Initiation:** ___________ **Current weight:** ________________

2) **Has the patient become pregnant?** Yes [ ] No [ ]

**Additional Comments:** ____________________________________________

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Revision Date: 12/17/14
The purpose of this record is for payment purposes. The patient’s medical record must substantiate the information provided on this form and compare for consistency. Medicaid reserves the right to request chart records to confirm the information provided above.

Practitioner Signature: ___________________________________________ Date: _________________