Anthem HealthKeepers Plus
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GLP-1 RAs for Obstructive Sleep Apnea Prior Authorization (PA) Form

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

Member information

Last name:	**First name:**
Medicaid ID number:	**Date of birth:**

Weight in kilograms: _____

Prescriber information

Last name:	**First name:**
NPI number:	
Phone number:	**Fax number:**

Drug information

For initial requests, continue below. For renewal requests, proceed to **Length of authorization**. If approved, initial authorizations are granted for six months. Renewal authorizations are granted for 12 months.

(Form continued on next page.)

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Member's last name: _____

Member's first name: _____

Drug name: _____ **Drug form:** _____

Drug strength: _____ **Dosing frequency:** _____

Length of therapy: _____ **Quantity per day:** _____

- FDA-indicated medications only

Diagnosis and medical information

_____

1. Is the member 18 years of age or older? **AND**
   ☐ Yes ☐ No

2. Is the requesting provider managing the member's obstructive sleep apnea? **AND**
   ☐ Yes ☐ No

3. Does the member have a diagnosis of moderate to severe obstructive sleep apnea (OSA), defined by an apnea-hypopnea index ≥ 15 events/hour and confirmed by polysomnography? **AND**
   ☐ Yes ☐ No

4. Is the member currently on or has the member tried, failed, or been unable to tolerate continuous positive airway pressure therapy (CPAP) (an adequate trial is defined as CPAP use for ≥ 4 hours per night on ≥ 70% of nights for two or more months)? **AND**
   ☐ Yes ☐ No

If unable to tolerate CPAP therapy, please explain the intolerance below:

_____

(Form continued on next page.)

Member's last name: **Member's first name:**

_____ _____

5. Does the member have a body mass index (BMI) of ≥ 30kg/m2? **AND**
   ☐ Yes ☐ No

6. Has the member participated in a weight loss treatment plan (for example, nutritional counseling, an exercise regimen, and calorie-restricted/fat-restricted diet) in the past 6 months and will they continue to follow this treatment plan while taking an anti-obesity medication for obstructive sleep apnea? **AND**
   ☐ Yes ☐ No

7. Does member have craniofacial abnormalities that may affect breathing? **AND**
   ☐ Yes ☐ No

8. Does the member have a diagnosis of central or mixed sleep apnea or Cheyne-Stokes respiration? **AND**
   ☐ Yes ☐ No

9. Is the member using any other GLP-1 product? **AND**
   ☐ Yes ☐ No

10. Does the member have pancreatitis, acute suicidal behavior/ideation, or gastroparesis, is the member using prokinetic drugs (metoclopramide), or does the member have a personal or family history of medullary thyroid cancer, or multiple endocrine neoplasia 2 syndrome?
    ☐ Yes ☐ No

Attestation and documentation

☐ Submission of polysomnography conducted within the last 12 months

☐ Submission of weight loss treatment plan within the past 6 months

(Form continued on next page.)

Member's last name: **Member's first name:**

_____ _____

Length of authorization

Renewal request (see additional requirements below):

1. Does the member continue to meet the criteria? **AND**
   ☐ Yes ☐ No

2. Is the member being treated with a maintenance dosage of the requested drug? **AND**
   ☐ Yes ☐ No

3. Is documentation attached verifying that the member has experienced improvement in OSA symptoms (for example, Epworth sleepiness scale, sleep questionnaire) as a measurement of OSA symptoms?
   ☐ Yes ☐ No

_____

☐ Attachments

Prescriber signature (required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include all requested information; Incomplete forms will delay the PA process.
Submission of documentation does **not** guarantee coverage.
The completed form may be faxed to **844-512-7020**.