Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Weight Loss Management 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

Drug name:		Drug form:	
Drug strength:		Dosing frequency:	
Length of therapy:		Quantity per day:	
Day supply:			

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Member information (repeated)

Last name:		First name:	

Diagnosis and medical information

If the physician does not have the necessary information, the request will be denied.

Coverage for these medications will be limited to the following:

Absence of medical contraindications:	☐ No contraindications to use (such as uncontrolled hypertension, hyperthyroidism etc. for stimulant-based products); **AND** ☐ No malabsorption syndromes, cholestasis, pregnancy, and/or lactation (for orlistat); **AND** ☐ No history of an eating disorder (for example, anorexia, bulimia); **AND** ☐ No acute pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer, or multiple endocrine neoplasia 2 syndrome (if requesting GLP-1 receptor agonists)
For all others except Imcivree®, additional qualifying criteria are:	☐ Participation in nutritional counseling; **AND** ☐ Participation in physical activity program, unless medically contraindicated; **AND** ☐ Commitment to continue the above weight loss treatment plan.

The provider attests that the patient's obesity is disabling and life-threatening (for example, puts the patient at risk for high morbidity conditions).	☐ Yes ☐ No

The written documentation must include the following:	☐ Medical status and weight-loss plan from within the last 60 days. An individualized weight-loss program should include a specific reduced-calorie meal plan, recommended routine physical activity, and behavioral intervention, including lifestyle modification as needed to improve adherence and outcomes; **AND** ☐ Accurate height and weight measurements from within the last 60 days

(Form continued on next page.)

Member information (repeated)

Last name:		First name:	

Summarize details of previous weight loss treatment plans to include diet and exercise plans, in addition to submitting a copy of the plan:	
Assessment:	
Other diagnoses/risk factors:	

Drug-specific criteria (minimum ages are per FDA approvals)

1. For phentermine (min. age 17), phendimetrazine tablet (min. age 18), phendimetrazine ER capsule (min. age 17), orlistat (min. age 12) and phentermine/topiramate (age 18 and older):
   - ☐ The member has a BMI of ≥ 30 kg/m2; **OR**
   - ☐ The member has a BMI of ≥ 27 kg/m2 with at least one weight-related comorbidity (for example, coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes).
2. For benzphetamine (min age 17), diethylpropion (min. age 16) and phentermine/topiramate (age 12-17):
   - ☐ The member has a BMI of ≥ 30 kg/m2.
3. For Imcivree® (min. age 2 years):
   - ☐ BMI ≥ 30 kg/m2; **AND**
   - ☐ Prescribed by or in consultation with an endocrinologist or geneticist; **AND**
   - ☐ Member has acquired hypothalamic obesity; **OR**
   - ☐ Member has Bardet-Biedl syndrome (BBS); **OR**
   - ☐ Member has proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test; **AND**
   - ☐ Member's genetic variants are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS).

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Member information (repeated)

Last name:		First name:	

4. For GLP-1 receptor agonists indicated for weight loss (Foundayo tablet [min age 18]), (Wegovy/Saxenda injections [min. age 12]), (Wegovy HD/tablet [min. age 18]), (Zepbound [min. age 18]):

☐ BMI > 40 kg/m2 if no applicable risk factors; **OR**

☐ BMI > 37 kg/m2 with one or more of the following risk factors: dyslipidemia, hypertension, or type 2 diabetes; **AND**

☐ Member has tried and failed one of the non-GLP1 weight loss medications*; **OR**

☐ Member is intolerant to all non-GLP1 weight loss medications*; **AND**

☐ Member not concurrently on another GLP-1 receptor agonists; **AND**

☐ The member has tried and failed* the selected product as indicated on the **Preferred Drug List (virginiamedicaidpharmacyservices.com)**.

5. For oral GLP-1 receptor agonists, in addition to confirmation of criteria in #4 above, please provide documentation of a medical contraindication** to an injectable product OR documented trial and failure of two injectable products:

_____
_____

**A medical contraindication is a specific patient condition in which the use of an injectable product increases the risk of a severe, life-threatening allergic or biological adverse reaction.

* Definitions of accepted drug trial	
Drug	**Trial**
Benzphetamine, diethylpropion, phendimetrazine, phentermine, phentermine/topiramate	Three month trial without a weight loss of 10 pounds
Orlistat	Six-month trial without a weight loss of 10 pounds
GLP-1 Receptor Agonist	Six-month trial without a body weight reduction of 5%

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Member information (repeated)

Last name:		First name:	

Length of authorization

☐ **Initial request:** Varies (drug-specific)

- Benzphetamine, diethylpropion, phendimetrazine, phentermine, phentermine/topiramate — three months
- GLP-1 receptor agonists — six months
- Orlistat — six months
- Imcivree® — four months

☐ **Renewal request:** Renewals will no longer be granted once a member reaches a BMI < 25. See additional requirements below (drug-specific). Renewals must be submitted within 30 days of the most recent authorization's expiration.

- **Benzphetamine, diethylpropion, phendimetrazine, phentermine, phentermine/topiramate:** If the member achieves at least a 10-pound weight loss during the initial three months of therapy, an additional three-month PA may be granted. Maximum length of continuous drug therapy is six months (waiting period of six months before next request).
- **Orlistat:** If the member achieves at least a 10-pound weight loss, an additional six-month PA may be granted. Maximum length of continuous drug therapy is 24 months (waiting period of six months before next request).
- **Imcivree®**: If the member has experienced ≥ 5% reduction in body weight (or ≥ 5% of baseline BMI in those with continued growth potential), an additional one year PA may be granted.
- **GLP-1 receptor agonists:** If the member achieves a weight loss of ≥ 5% reduction in body weight compared to the most recent authorization, an additional six-month PA may be granted.

☐ Check if additional documents will be uploaded.

All approvals are subject to the criteria on this form. Existing authorizations will be honored until renewal.

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Member information (repeated)

Last name:		First name:	

Prescriber signature (required) By signature, the physician confirms the above information is accurate and verifiable by member records.	
	Date

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**.