Print Reset

Weight Management Agents
Choice Prior Authorization Request Prescriber Fax
Fax this form to 800-424-3260

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit web.primetherapeutics.com/provider/forms or primetherapeutics.com/commercial-formularies.

What is the priority level of this request?

- ☐ Standard
- ☐ Date of service (if applicable): _____
- ☐ Urgent (**Note:** Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA FOR ALL REQUESTS

Note: Please attach any additional information that should be considered with this request.

Patient's Diagnosis: Please select.

☐ Obstructive Sleep Apnea (OSA)

☐ Obesity

☐ Overweight

☐ To reduce the risk of major adverse cardiovascular events in adults with established cardiovascular disease and the patient is either obese or overweight

☐ Metabolic dysfunction associated steatohepatitis (MASH) formerly known as nonalcoholic steatohepatitis (NASH)

☐ Other (ICD 10 and description below):

ICD code: _____

ICD description: _____

1. What is the patient's **baseline** weight and body mass index (BMI) prior to initiation of requested agent?

   Baseline Weight: _____ kg Baseline BMI: _____ kg/m^2

2. Is the patient currently treated with the requested agent?

   ☐ Yes ☐ No

   If Yes, when was therapy with the requested agent started?

   _____

   If Yes, please specify the following:

   Current Weight: _____ kg Current BMI: _____ kg/m^2

   Percent weight loss from baseline: _____ %

3. Does the patient have any FDA-labeled contraindications to the requested agent?

   ☐ Yes ☐ No

   If Yes, please specify contraindication(s):

   _____

Patient's Name (Last, First): _____

4. Will the patient be using the requested agent in combination with another GLP-1 receptor agonist (e.g., Saxenda, Wegovy, Zepbound, Adlyxin, Bydureon, Byetta, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza)?
   ☐ Yes ☐ No
5. Will the patient be using the requested agent in combination with another weight-loss agent (e.g., Contrave, phentermine, Qsymia, Xenical)?
   ☐ Yes ☐ No
6. Is the patient currently on and will continue a weight-loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications?
   ☐ Yes ☐ No

   If Yes, will the patient continue the weight loss regimen in combination with the requested agent?
   ☐ Yes ☐ No
7. Is the patient's age within FDA labeling for the requested indication for the requested agent?
   ☐ Yes ☐ No

   If No, is there information in support of using the requested agent for the patient's age?
   ☐ Yes ☐ No

   If Yes, please explain:

   _____
8. Please list all medications that the patient has previously tried and had an inadequate response, intolerance or contraindication to for the treatment of this diagnosis. Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

Patient's Name (Last, First): _____

CRITERIA FOR OBSTRUCTIVE SLEEP APNEA (OSA)

9. Is the requested agent Zepbound?

   ☐ Yes ☐ No

10. Has the patient had a polysomnography (PSG) or home sleep apnea test **(medical records required)**?

    ☐ Yes ☐ No

11. Does the patient have an apnea hypopnea index (AHI) greater than or equal to 15 from baseline (prior to initiation of pharmacotherapy [**medical records required**])?

    ☐ Yes ☐ No

12. Does the patient have a BMI greater than or equal to 30 kg/m^2 (**medical records required)**?

    ☐ Yes ☐ No

CRITERIA FOR NON-CIRRHOTIC METABOLIC DYSFUNCTION ASSOCIATED STEATOHEPATITIS (MASH), FORMERLY KNOWN AS NON-ALCOHOLIC STEATOHEPATITIS (NASH)

Note: Medical records are required.

13. Is the request for Wegovy?

    ☐ Yes ☐ No

14. Are there medical records showing the patient have a diagnosis of non-cirrhotic metabolic dysfunction associated steatohepatitis (MASH) formulary known as non-alcoholic steatohepatitis (NASH)? **If Yes, please submit medical records.**

    ☐ Yes ☐ No

15. Does patient have stage F2 or F3 fibrosis confirmed by one of the following?

    Select all that apply (medical records required).

    ☐ A liver biopsy
    ☐ Vibration-controlled transient elastography (VCTE)
    ☐ Enhanced liver fibrosis (ELF) score
    ☐ Magnetic resonance elastography (MRE)
    ☐ None of the above

16. If the patient's sex is female, is the patient's alcohol consumption less than 20 grams/day (medical records required)? **Note:** One standard alcoholic drink contains roughly 14 grams of pure alcohol, which is found in 12 ounces of regular beer, 5 ounces of wine, or 1.5 ounces of distilled spirits.

    ☐ Yes ☐ No

17. If the patient's sex is male, is the patient's alcohol consumption less than 30 grams/day? (medical records required) **Note:** One standard alcoholic drink contains roughly 14 grams of pure alcohol, which is found in 12 ounces of regular beer, 5 ounces of wine, or 1.5 ounces of distilled spirits.

    ☐ Yes ☐ No

Patient's Name (Last, First): _____

18. Is the patient being monitored and/or treated for any comorbid conditions (e.g., cardiovascular disease, diabetes, dyslipidemia, hypertension [**medical records required**])?
    ☐ Yes ☐ No
19. Is it confirmed that the patient is free from decompensated cirrhosis, moderate to severe hepatic impairment (e.g., Child-Pugh Class B or C), or any other liver disease (e.g., Wilson's disease, hepatocellular carcinoma, hepatitis? (**Medical records required**.)
    ☐ Yes ☐ No
20. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., hepatologist, gastroenterologist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis?
    ☐ Yes ☐ No

Please list specialty: _____

CRITERIA FOR REDUCTION OF RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (CARDIOVASCULAR DEATH, NON-FATAL MYOCARDIAL INFARCTION, OR NON-FATAL STROKE) IN ADULTS WITH ESTABLISHED CARDIOVASCULAR DISEASE AND EITHER OBESITY OR OVERWEIGHT REQUESTS

21. Does the patient have a history of at least one of the following: myocardial infarction, stroke, or, peripheral artery disease?
    ☐ Yes ☐ No

    If **Yes**, select all that apply:
    ☐ Myocardial infarction
    ☐ Stroke
    ☐ Peripheral artery disease as defined by intermittent claudication with ankle-brachial index less than 0.85 at rest, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease
22. Does the patient have a BMI greater than or equal to 27 kg/m^2?
    ☐ Yes ☐ No
23. Will the patient use optimized pharmacotherapy for established cardiovascular disease in combination with the requested agent?
    ☐ Yes ☐ No

CRITERIA FOR ZEPBOUND

24. Is the patient newly starting therapy?
    ☐ Yes ☐ No

    If No, is the patient currently being treated with Zepbound and has received **less** than 52 weeks (1 year) of therapy?
    ☐ Yes ☐ No

    If No, has the patient achieved and maintained a **weight** loss of greater than or equal to 5% from baseline (prior to initiation of pharmacotherapy)?
    ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA FOR OBESITY OR OVERWEIGHT FOR WEIGHT MANAGEMENT REQUESTS

25. Is the patient continuing therapy **or** attempting a repeated weight loss course of therapy? **Select one.**
    - ☐ Attempting repeated weight loss course of therapy
    - ☐ Continuing therapy

    What is the patient's BMI? _____ kg/m^2
26. Is the patient of South Asian, Southeast Asian, or East Asian descent?
    - ☐ Yes ☐ No
27. Does the patient have at least one weight-related comorbidity/risk factor/complication? **Select all that apply**.
    - ☐ Hypertension
    - ☐ Type 2 diabetes mellitus
    - ☐ Obstructive sleep apnea
    - ☐ Cardiovascular disease
    - ☐ Dyslipidemia
    - ☐ Other, please specify: _____
28. For **pediatric** patients (12 to 17 years of age) does the patient have any of the following? **Select all that apply**.
    - ☐ A BMI greater than or equal to 95th percentile for age and sex
    - ☐ A BMI greater than or equal to 30 kg/m^2
    - ☐ A BMI greater than or equal to 85th percentile for age and sex **and** at least one weight-related comorbidity/risk factor/complication (e.g., hypertension, dyslipidemia, type 2 diabetes, obstructive sleep apnea)
29. Has the patient been on a weight loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications for a minimum of 6 months?
    - ☐ Yes ☐ No
30. Has the patient tried a targeted weight loss agent (Saxenda, Wegovy, Zepbound) for a previous course of therapy in the past 12 months?
    - ☐ Yes ☐ No

    If Yes, does the prescriber anticipate success for the patient with repeating therapy?
    - ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA FOR SAXENDA

For a pediatric patient (12 to 17 years of age)

31. Is the patient newly starting therapy?

☐ Yes ☐ No

If No, is the patient currently being treated with Saxenda and has received less than 20 weeks (5 months) of therapy?

☐ Yes ☐ No

If No, has the patient achieved and maintained a reduction in BMI of greater than or equal to 1% from baseline (prior to initiation of pharmacotherapy)?

☐ Yes ☐ No

For an adult patient (18 years of age and older)

32. Is the patient newly starting therapy?

☐ Yes ☐ No

If No, is the patient currently being treated with Saxenda and has received less than 16 weeks (4 months) of therapy?

☐ Yes ☐ No

If No, has the patient achieved and maintained a weight loss of greater than or equal to 4% from baseline (prior to initiation of pharmacotherapy)?

☐ Yes ☐ No

CRITERIA FOR WEGOVY

33. Is the patient newly starting therapy?

☐ Yes ☐ No

If No, is the patient currently being treated with Wegovy and has received **less** than 52 weeks (1 year) of therapy?

☐ Yes ☐ No

If No, for **pediatric** patients (12 to 17 years of age):

Has the patient achieved and maintained a reduction in **BMI** of at least 5% from baseline (prior to initiation of pharmacotherapy)?

☐ Yes ☐ No

If No, for **adult** patients (18 years of age or over):

Has the patient achieved and maintained a **weight** loss of greater than or equal to 5% from baseline (prior to initiation of pharmacotherapy)?

☐ Yes ☐ No

Patient's Name (Last, First): _____

34. Will the patient be using Wegovy 0.5 mg or 1 mg for maintenance therapy?
    ☐ Yes ☐ No

    If Yes, answer the following:

    Does the patient have an inability to use an FDA labeled strength indicated for maintenance therapy?
    ☐ Yes ☐ No

    Has the patient achieved weight loss on the lower requested strength from baseline (prior to initiation of pharmacotherapy)?
    ☐ Yes ☐ No

    Please provide details:

    _____

RENEWAL FOR DIAGNOSIS OF NONCIRRHOTIC METABOLIC DYSFUNCTION ASSOCIATED STEATOHEPATITIS (MASH) FORMERLY KNOWN AS NONALCOHOLIC STEATOHEPATITIS (NASH)

35. Is the requested agent Wegovy?
    ☐ Yes ☐ No
36. Has the patient had clinical benefit with the requested agent?
    ☐ Yes ☐ No

RENEWAL CRITERIA FOR OBSTRUCTIVE SLEEP APNEA

37. Is the requested agent Zepbound?
    ☐ Yes ☐ No
38. Has the patient had clinical benefit with the requested agent (e.g., reduction in AHI, decrease in Epworth Sleepiness Scale)?
    ☐ Yes ☐ No

RENEWAL CRITERIA FOR REDUCTION OF RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (CARDIOVASCULAR DEATH, NON-FATAL MYOCARDIAL INFARCTION, OR NON-FATAL STROKE) IN ADULTS WITH ESTABLISHED CARDIOVASCULAR DISEASE AND EITHER OBESITY OR OVERWEIGHT RENEWAL REQUESTS

39. Has the patient had clinical benefit with the requested agent?
    ☐ Yes ☐ No
40. Will the patient use optimized pharmacotherapy for established cardiovascular disease in combination with the requested agent?
    ☐ Yes ☐ No

Patient's Name (Last, First): _____

RENEWAL CRITERIA FOR OBESITY OR OVERWEIGHT FOR WEIGHT MANAGEMENT

41. Is the patient overweight or obese and using the requested agent for weight management?

☐ Yes ☐ No

42. Is the patient continuing a current weight loss course of therapy?

☐ Yes ☐ No

43. If the patient is pediatric (12–17 years of age), is the patient's current BMI greater than or equal to the 85th percentile for their age and sex?

☐ Yes ☐ No

44. Has the patient achieved and maintained a weight loss greater than or equal to 5% from baseline (prior to the initiation of requested agent)?

☐ Yes ☐ No

45. **For Saxenda** (18 years of age or older), has the patient achieved and maintained a weight loss greater than or equal to 4% from baseline (prior to initiation of pharmacotherapy)?

☐ Yes ☐ No

For pediatric (12 to 17 years of age): **If No**, has the patient achieved and maintained a reduction in **BMI** of greater than or equal to 1% from baseline (prior to initiation of pharmacotherapy)?

☐ Yes ☐ No

46. **For Wegovy**, has the patient received less than 52 weeks of therapy on the maximum-tolerated dose?

☐ Yes ☐ No

For pediatric (12 to 17 years of age): **If No,** has the patient achieved and maintained a reduction in **BMI** of at least 5% from baseline (prior to initiation of pharmacotherapy)?

☐ Yes ☐ No

47. For **Zepbound,** has the patient received less than 52 weeks of therapy on the maximum-tolerated dose?

☐ Yes ☐ No

RENEWAL CRITERIA FOR ALL OTHER DIAGNOSES

48. Has the patient had clinical benefit with the requested agent?

☐ Yes ☐ No

QUANTITY LIMIT REQUEST

49. Is quantity requested greater than program quantity limit?

☐ Yes ☐ No

If Yes, please provide support for therapy with a higher dose for the requested indication.

_____

☐ Attachments

Patient's Name (Last, First): _____

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 1-800-424-3312

Fax this form to 800-424-3260

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