OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Obesity Treatment Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	
Strength & package size/quantity/refills:	
Additional strengths / quantity for each / refills for each to allow for dose titration:	
Directions:	
Diagnosis *(submit documentation)*:	Dx code (*required*):
Does the member have any contraindications to the requested medication?	☐Yes ☐No *Submit documentation.*

ATTESTATION from the prescriber: Was member recently counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity?	☐Yes ☐No

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. **The member is 18 years of age or older and:**

   Pre-treatment weight: _____ Pre-treatment BMI: _____

   ☐Has a BMI greater than or equal to 30 kg/m^2

   ☐Has a BMI greater than or equal 27 kg/m^2 and less than 30 kg/m^2 AND at least one of the following weight-related comorbidities:

   - ☐cardiovascular disease
   - ☐dyslipidemia
   - ☐hypertension
   - ☐metabolic syndrome
   - ☐obstructive sleep apnea
   - ☐prediabetes
   - ☐type 2 diabetes
   - ☐other (list): _____

   ☐Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for member's ethnicity, etc. AND has at least one of the following weight-related comorbidities:

   - ☐cardiovascular disease
   - ☐dyslipidemia
   - ☐hypertension
   - ☐metabolic syndrome
   - ☐obstructive sleep apnea
   - ☐prediabetes
   - ☐type 2 diabetes
   - ☐other (list): _____

2. **The member is less than 18 years of age and:**

   Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

   ☐Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

3. **Request is for EVEKEO (amphetamine) ODT/tablet:**

   ☐Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history

   ☐Was educated regarding the potential adverse effects of stimulants, including the risk of misuse, abuse, and addiction

   ☐Has a history of trial and failure of or a contraindication or an intolerance to all other Obesity Treatment Agents (preferred and non-preferred)

   ☐Has prescriber documentation explaining why Evekeo (amphetamine) is needed and a plan for tapering

   ☐**For a member with a history of substance dependency, abuse, or diversion:**

   ☐Has results of a recent UDS for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

4. **Request is for a PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST (eg, Saxenda, Wegovy, Zepbound)** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)***:**

   ☐Has a concurrent diagnosis of diabetes mellitus OR has taken an antidiabetic drug in the last 120 days AND:

   ☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist:

   - ☐Ozempic
   - ☐Trulicity

☐ Victoza

☐ Does NOT have diabetes mellitus and has NOT taken an antidiabetic drug in the past 120 days

5. **Request is for a NON-PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*:
   - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:
     - ☐ Saxenda
     - ☐ Wegovy
     - ☐ Zepbound
   - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:
     - ☐ Ozempic
     - ☐ Trulicity
     - ☐ Victoza

6. **Request is for ANY OTHER NON-PREFERRED Obesity Treatment Agent (ie, NOT Evekeo [amphetamine] or a drug containing a GLP-1 receptor agonist)** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*:
   - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the member's diagnosis or indication:
     - ☐ phentermine capsule or tablet
     - ☐ Saxenda
     - ☐ Wegovy
     - ☐ Zepbound

RENEWAL requests

1. **For a member is 18 years of age or older:**

   Pre-treatment weight: _____ Current weight: _____

2. **For a member is less than 18 years of age:**

   Pre-treatment BMI: _____ Current BMI: _____

   Pre-treatment BMI z-score: _____ Current BMI z-score: _____

3. **All requests:**
   - ☐ The dose of the requested medication is currently being titrated
   - ☐ The member experienced a percent reduction in body weight (for beneficiaries 18 years of age or older) or BMI or BMI z-score (for beneficiaries less than 18 years of age) that is consistent with the recommended cutoff in the FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after 3 months of therapy with the maximum recommended/tolerated dose
   - ☐ The member experienced an improvement in degree of adiposity or waist circumference from baseline
   - ☐ The member experienced clinical benefit with the requested medication in at least one weight-related comorbidity from baseline, such as dyslipidemia, hypertension, type 2 diabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.

4. **Request is for Evekeo (amphetamine) ODT/tablet:**
   - ☐ Has prescriber documentation explaining why Evekeo (amphetamine) is needed and a plan for tapering (*submit documentation)*
   - ☐ **For a member with a history of substance dependency, abuse, or diversion:**
     - ☐ Has results of a recent UDS for licit & illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

5. **Request is for a NON-PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST** *(Refer to*

https://papdl.com/preferred-drug-list *for a list of preferred and non-preferred drugs in this class.)*:

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:

- ☐ Saxenda
- ☐ Wegovy
- ☐ Zepbound

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a GLP-1 receptor agonist that are medically accepted for the member's diagnosis:

- ☐ Ozempic
- ☐ Trulicity
- ☐ Victoza

6. **Request is for ANY OTHER NON-PREFERRED Obesity Treatment Agent (ie, NOT Evekeo [amphetamine] or a drug containing a GLP-1 receptor agonist)** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*:

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the member's diagnosis or indication:

- ☐ phentermine capsule or tablet
- ☐ Saxenda
- ☐ Wegovy
- ☐ Zepbound

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)