MOLINA HEALTHCARE
Service Authorization (SA) Form
WEIGHT LOSS MANAGEMENT

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

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

All weight loss medications will require a SA, which include, but are not limited to, the following:

- ☐ Adipex-P®/Suprenza™ (phentermine)
- ☐ Alli®/Xenical® (orlista)
- ☐ Bontril®/Bontril PDM® (phendimetrazine)
- ☐ Contrave® (bupropion SR/naltrexone SR)
- ☐ Didrex®/Regimex® (benzphetamine)
- ☐ Imcivree™ (setmelanotide)
- ☐ Qsymia® (phentermine/topiramate ER)
- ☐ Radtue® (diethylpropion)
- ☐ Saxenda® (liraglutide)
- ☐ Wegovy™ (semaglutide)

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revised: 1/1/2023 | Effective: 1/1/2023

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

If the physician does not have the necessary information, the request will be denied and the fax form requesting additional information will be sent to the prescriber.

Coverage for these medications will be limited to the following:

1. Body mass index (**BMI) requirements:**
   - ☐ BMI ≥ 30, if no applicable risk factors
   - ☐ BMI ≥ 27 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type II diabetes
   - ☐ BMI ≥ 30 or ≥ 95th percentile on pediatric growth chart **(Imcivree™)**
   - ☐ Body weight above 60 kg and an initial BMI corresponding to 30 kg/m^2 for adults (obese) by international cut-offs **(Saxenda® in pediatric patients 12 years of age and older)**
2. **Age restrictions:**
   - ☐ Covered only for members 16 years of age or older
   - ☐ Saxenda only covered for members 12 years of age or older
   - ☐ Imcivree only covered for members 6 years of age or older
   - ☐ Wegovy only covered for members 18 years of age or older
3. **Initial Request Requirements:**
   - ☐ No contraindications to use; **AND**
   - ☐ No malabsorption syndromes, cholestasis, pregnancy, and/or lactation; **AND**
   - ☐ No history of an eating disorder (e.g., anorexia, bulimia); **AND**
   - ☐ Previous failure of a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen and a calorie/fat-restricted diet) in the past 6 months and will continue to follow as part of the treatment plan **(excludes Imcivree™)**; **OR**

     Specific to Imcivree™ ONLY

     - ☐ Prescribed by or in consultation with an endocrinologist or geneticist**; AND**
     - ☐ 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)

(Form continued on next page.)

 Revised: 1/1/2023 | Effective: 1/1/2023

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

4. **The written documentation must include:**
   - ☐ Current medical status including nutritional or dietetic assessment
   - ☐ Current therapy for all medical conditions (including obesity), identifying specific treatments including medications
   - ☐ Current accurate height and weight measurements
   - ☐ No medical contraindications to use a reversible lipase inhibitor (**Xenical®**)
   - ☐ Current weight loss plan or program including diet and exercise plan
   - ☐ No chronic opioid use concurrently with **Contrave®**
   - ☐ Member not concurrently on Victoza or Ozempic or other GLP-1 inhibitors (**Saxenda® and Wegovy™**)

5. **Length of Authorization:**
   - ☐ **Initial request: Varies (drug specific)**
     - Benzphetamine, diethylpropion, phendimetrazine, phentermine, Qsymia, Contrave®, – 3 months
     - Wegovy™- 6 months
     - Alli®/Xenical® – 6 months
     - Saxenda® and Imcivree™ – 4 months
   - ☐ **Renewal requests: Varies (drug specific)**
     - **Benzphetamine**, **diethylpropion**, **phendimetrazine**, **phentermine** – If the member achieves at least a 10 lb. weight loss during the initial 3 months of therapy, an additional 3-month SA may be granted. Maximum length of continuous drug therapy is 6 months (waiting period of 6 months before next request).
     - **Qsymia®** – If the member achieves a weight loss of at least 3% of baseline weight, an additional 3-month SA may be granted. For a subsequent renewal, member must meet a weight loss of at least 5% of baseline weight to qualify for an additional 6-month SA. Maximum length of continuous drug therapy is 12 months (waiting period of 6 months before next request).
     - **Alli®/Xenical®** – If the member achieves at least a 10 lb. weight loss, an additional 6-month SA may be granted. Maximum length of continuous drug therapy is 24 months (waiting period of 6 months before next request).
     - **Contrave®** – Approve for 6 months with each renewal if weight reduction continues.
     - **Saxenda®** – If the member achieves a weight loss of at least 4% of baseline weight, an additional 6-month SA may be granted as long as weight reduction continues.
     - **Imcivree™** – If the member has experienced ≥ 5% reduction in body weight (or ≥ 5% of baseline BMI in those with continued growth potential), an additional 1 year SA may be granted.
     - **Wegovy™ - If the member achieves a weight loss of at least 5% of baseline weight, an additional 6 month SA may be granted.**

   Note – Renewal SA requests will **NOT** be authorized if the member's BMI is < 24.

(Form continued on next page.)

Member's Last Name:

Member's First Name:

6. **Assessment**:

_____

7. **Other Diagnoses/Risk Factors**:

_____

8. **Current Medications**: _____

9. **Current BMI:** _____ **Height:** _____

10. **Are there any contraindication for this use, malabsorption syndromes, cholestasis, pregnancy, and/or lactation?**

☐ Yes ☐ No

If YES, please describe: _____

Document details of previous weight loss treatment plans to include diet and exercise plans. Submit copy of plan. Additional Comments:

_____

_____ _____

Prescriber Signature (Required) **Date**

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

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 SA process.
Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **FAXED to 1-844-278-5731**, or you may call **(800) 424-4518 (TTY: 711)**.

