AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Saxenda

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity per 30 days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days __Other:_____

Clinical Information

Initial Request: Saxenda for Weight Loss **Medical records are required for Weight Loss prior authorization review.***

1. Please list the beneficiary's baseline weight and BMI. Weight_____ Date_____ BMI_____ Date_____
2. Is the beneficiary 18 years of age or older? Yes___ No___
   2a. Does the beneficiary have a BMI greater than or equal to 30 kg/m^2? Yes___ No___
   2b. Does the beneficiary have a BMI greater than or equal to 27 kg/m^2? Yes___ No___
      2b-i. Does the beneficiary have at least one weight-related comorbidity/risk factor/complication (i.e., hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? Yes___ No___
      Attach medical records to confirm weight-related comorbidity/risk factor/complication.
3. Is the beneficiary between 12-17 years of age? Yes___ No___
   3a. Does the beneficiary have a BMI greater than or equal to the 95th percentile for age and sex? Yes___ No___
   3b. Does the beneficiary have a BMI greater than or equal to 30 kg/m^2? Yes___ No___
   3c. Does the beneficiary have a BMI greater than or equal to the 85th percentile for age and sex? Yes___ No___
      3c-i. Does the beneficiary have at least one weight-related comorbidity/risk factor/complication (i.e., hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? Yes___ No___
      Attach medical records to confirm weight-related comorbidity/risk factor/complication.
4. Is the beneficiary 45 years of age or older? Yes___ No___
   4a. Does the beneficiary have a BMI greater than or equal to 27 kg/m^2? Yes___ No___
      4a-i. Does the beneficiary have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral disease? Yes___ No___
      Attach medical records to confirm CVD.
5. Is the beneficiary currently on and will the beneficiary continue lifestyle modification including structured nutrition and physical activity, unless physical activity is not clinically appropriate at the time GLP1 therapy commences? Yes___ No___
Attach medical records to confirm nutrition and physical activity status.
6. Will the beneficiary be using the requested agent with another GLP-1? Yes___ No___
7. Does the beneficiary have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? Yes___ No___

Continuation Request: Saxenda Weight Loss ***Medical records are required for Weight Loss prior authorization review.***

1. Beneficiary's baseline and current weight. Baseline Weight_____ Date_____ Current Weight_____ Date_____
2. Beneficiary's baseline and current BMI. Baseline BMI_____ Date_____ Current BMI_____ Date_____
3. Is the beneficiary continuing a current weight loss course of therapy? Yes___ No___
4. **Ages 18 and older –** Has the beneficiary lost a total of 5% of pretreatment weight and is maintaining the 5% weight loss? Yes___ No___ Baseline Weight_____ Current Weight_____
5. **Ages ≥ 12 to <18 years –** Has the beneficiary had >4% reduction in baseline BMI and is maintaining the weight loss? Yes___ No___ Baseline Weight_____ Current Weight_____
6. Does the beneficiary have a documented weight loss that is deemed to be a significant reduction from BMI per the prescriber and the weight loss is maintained, yet the 5% (for adults) and 4% (for adolescents) is not met? Yes___ No___
Rationale: _____

Signature of Prescriber: _____ Date: _____
***Prescriber signature mandatory**
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406