Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Weight Management Agents (WEGOVY, SAXENDA, & ZEPBOUND) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Weight Management Agents (WEGOVY, SAXENDA, & ZEPBOUND)** for **Commercial** and **FEHB (Federal)** plans**.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the patient enrolled in KPMAS Clinical Pharmacy Weight Management Service (or medication is being prescribed by Endocrinologist or Weight Management Specialist)?
   □ No □ Yes

2. Does the patient meet the age cutoffs for use of the medication?
   - At least 12 years of age: Wegovy and Saxenda
   - At least 18 years of age: Zepbound

   □ No □ Yes

3. Is the baseline BMI ≥30 kg/m^2 (without weight-related comorbidity), OR between 27 to <30 kg/m^2 with at **least one** of the following weight-related comorbidities?
   ☐ N/A, baseline BMI ≥30 kg/m^2
   ☐ Established cardiovascular disease or stroke
   ☐ Hypertension
   ☐ Type 2 DM
   ☐ CKD
   ☐ CHD
   ☐ Obstructive sleep apnea
   ☐ Polycystic ovarian syndrome
   ☐ Dyslipidemia
   ☐ Non-alcoholic fatty liver disease
   ☐ Idiopathic intracranial hypertension
   ☐ Osteoarthritis in weight-bearing joints

4. Does the patient have a documented baseline weight?
   □ No □ Yes

5. Is the patient currently enrolled in and/or following a lifestyle intervention program [examples include, but are not limited to, the KP Diabetes Prevention Program (DPP) or external program(s) (e.g., Weight Watchers, Noom, Jenny Craig, etc.)], and will continue with lifestyle modifications while on Wegovy, Saxenda, or Zepbound?
   □ No □ Yes

6. Does the patient have a documented intolerance, contraindication or failure to lose and maintain greater than or equal to 5% body weight after a 3-month trial of ALL of the following medications indicated for chronic weight management?
   - Qsymia (phentermine IR + topiramate XR) or phentermine and topiramate used at similar doses and prescribed simultaneously
   - Contrave (naltrexone + bupropion) or naltrexone and bupropion used at similar doses and prescribed simultaneously
   - Wegovy (semaglutide)* (after 3-month trial at maximum tolerated dose)
   - Xenical (orlistat)

   □ No □ Yes

7. Are Wegovy, Saxenda, and Zepbound being used in combination with another weight loss drug (or GIP/GLP-1 RA or GLP-1 RA)?
   □ No □ Yes

8. Is the initial prescription limited to a maximum of 30-day supply with 2 refills?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Does the patient continue to meet initial review criteria above?
   □ No □ Yes

2. Is there documented weight loss within the previous 3 months of at least 5% from baseline weight?
   □ No □ Yes

Note: * Indicates requirement for Saxenda & Zepbound only.

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**