

GLP-1s For Weight Management Prior Authorization Form

Member information		
1. Member last name:		2. Member first name:
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber information		
6. Prescribing provider NPI #:		
7. Prescriber contact information		
Name:		
Phone:	Ext:	
Drug information		
8. Drug name:	9. Strength:	
10. Quantity per 30 days:		
11. Length of therapy (in days): <input type="checkbox"/> up to 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days <input type="checkbox"/> Other: _____		
Clinical information		
Initial request (Wegovy, Saxenda, and Zepbound):		
1. Please list the member's baseline weight and BMI. Weight _____ Date _____ BMI _____ Date _____		
2. Is the member 18 years or age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2a. Does the member have a BMI greater than or equal to 30 kg/m ² ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2b. Does the member have a BMI greater than or equal to 27 kg/m ² ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2b-i. Does the member have at least one weight-related comorbidity/risk factor/complication (i.e. hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? <input type="checkbox"/> Yes <input type="checkbox"/> No List:		
3. Is the member between 12-17 years or age? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3a. Does the member have a BMI greater than or equal to the 95 th percentile for age and sex? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<https://provider.healthybluenc.com>

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3b. Does the member have a BMI greater than or equal to 30 kg/m ² ? <input type="checkbox"/> Yes <input type="checkbox"/> No
3c. Does the member have a BMI greater than or equal to the 85 th percentile for age and sex? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3c-i. Does the member have at least one weight-related comorbidity/risk factor/complication (i.e. hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? <input type="checkbox"/> Yes <input type="checkbox"/> No List:
4. Is the member aged 45 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
4a. Does the member have a BMI greater than or equal to 27 kg/m ² ? <input type="checkbox"/> Yes <input type="checkbox"/> No
4a-i. Does the member have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral disease? <input type="checkbox"/> Yes <input type="checkbox"/> No List:
5. Is the member currently on and will the member continue lifestyle modification including structured nutrition and physical activity, unless physical activity is not clinically appropriate at the time GLP1 therapy commences? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Will the member be using the requested agent with another GLP-1? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does the member have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer, or multiple endocrine neoplasia type II? <input type="checkbox"/> Yes <input type="checkbox"/> No
Continuation request (Wegovy, Saxenda, and Zepbound):
8. Has the member previously been approved for the requested agent through NC Medicaid's Prior Authorization process? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Member's baseline and current weight. Baseline Wt. _____ Date _____ Current Weight _____ Date _____
10. Member's baseline and current BMI. Baseline BMI _____ Date _____ Current BMI _____ Date _____
11. Is the member continuing a current weight loss course of therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Ages 18 and older- Has the member lost a total of 5% of pretreatment weight and is maintaining the 5% weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No Baseline Weight _____ Current Weight _____
13. Ages (>12 to <18 years)- Has the member had >4% reduction in baseline BMI and is maintaining the weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No Baseline Weight _____ Current Weight _____
14. Does the member 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Rationale _____
15. Is the member currently on and will continue lifestyle modification including structured nutrition and physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Will the member be using the requested agent with another GLP-1? <input type="checkbox"/> Yes <input type="checkbox"/> No

17. Does the member 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

Request for non-preferred drug (Saxenda, and Zepbound)

1. Failed preferred drug(s). List preferred drugs failed:

1a. Allergic reaction 1b. Drug-to-drug interaction. Please describe reaction:

2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information

3. Clinical contraindication, co-morbidity, or unique member circumstance as a contraindication to preferred drug(s). Please provide clinical information:

4. Age specific indications. Please give member age and explain:

5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:

6. Unacceptable clinical risk associated with therapeutic change. Please explain:

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 **844-376-2318**.

Healthy Blue and Healthy Blue Care Together pharmacy prior authorization call center: **844-594-5072**
(Healthy Blue Provider Services) or **833-777-3698** (Healthy Blue Care Together Provider Services)