

Humana Healthy Horizons in Virginia request form

Weight-loss management

If the following information is not complete, correct or legible, the prior authorization (PA) process can be delayed. Please use one form per member.

Member information

Last name:

First name:

Medicaid ID number:

Date of birth:

Weight in kilograms:

Provider information

Last name:

First name:

NPI number:

Phone number:

Fax number:

Medication information

For initial requests, continue below. For renewal requests, proceed to page 4 of this form.

Drug name:

Drug form:

Drug strength:

Drug frequency:

Length of therapy:

Quantity:

Day supply:

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 provider.

Coverage for all medications will be limited to the following:

Absence of medical contraindications:

No contraindications to use (uncontrolled hypertension, hyperthyroidism, etc. for stimulant-based products); **and**

No malabsorption syndromes, cholestasis, pregnancy and/or lactation (for orlistat); **and**

Humana Healthy Horizons® in Virginia

Humana Healthy Horizons in Virginia is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation.

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Diagnosis and medical information

No history of an eating disorder (e.g., anorexia, bulimia); **and**

No acute pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer, or multiple endocrine neoplasia 2 syndrome (if requesting a GLP-1 receptor agonist)

For all others except Imcivree[®], additional qualifying criteria are:

Participation in nutritional counseling; **and**

Participation in physical activity program, unless medically contraindicated; **and**

Commitment to continue the above weight-loss treatment plan

The provider attests that the patient's obesity is disabling and life threatening (i.e., puts the patient at risk for high-morbidity conditions):

Yes

No

The written documentation must include the following:

Current medical status and weight-loss plan. An individualized weight-loss program should include a specific, reduced-calorie meal plan, recommended routine physical activity and behavioral intervention, including lifestyle modification as needed to improve adherence and outcomes; **and**

Current accurate height and weight measurements

Summarize details of previous weight-loss treatment plans to include diet and exercise plans, in addition to submitting a copy of the plan:

Assessment:

Other diagnoses/risk factors:

Drug-specific criteria (minimum ages are per FDA approvals)

1. Drug-specific criteria (minimum ages are per FDA approvals)

The member has a BMI of ≥ 30 kg/m²; **or**

The member has a BMI of ≥ 27 kg/m² with at least one weight-related comorbidity (coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes)

2. For benzphetamine (min. age 17), diethylpropion (min. age 16):

The member has a BMI of ≥ 30 kg/m²

3. For Imcivree (min. age 6):

BMI ≥ 30 kg/m²; **and**

Prescribed by or in consultation with an endocrinologist or geneticist; **and**

Member has Bardet-Biedl syndrome (BBS); **or**

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)

4. For GLP-1 receptor agonists indicated for weight loss (Wegovy[®]/Saxenda[®] min. age 12, Zepbound[®] min. age 18):

BMI > 40 kg/m², if no applicable risk factors; **or**

BMI > 37 kg/m² with one or more of the following risk factors: dyslipidemia, hypertension, type 2 diabetes; **and**

Member has tried and failed one of the non-GLP1 weight-loss medications*; **or**

Member is intolerant to all non-GLP1 weight-loss medications*; **and**

Member not concurrently on other GLP-1 receptor agonists; **and**

The member has tried and failed* the selected product as indicated on the PDL:

www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list/

* Definitions of accepted drug trial

Drug name	Trial
Benzphetamine, diethylpropion, phendimetrazine, phentermine	3-month trial without a weight loss of 10 lbs
Orlistat	6-month trial without a weight loss of 10 lbs
GLP-1 receptor agonist	6-month trial without a body weight reduction of 5%

Length of authorization

Initial request: varies (drug specific)

- Benzphetamine, diethylpropion, phendimetrazine, phentermine – 3 months
- GLP-1 receptor agonists – 6 months
- Orlistat – 6 months
- Imcivree – 4 months

Renewal request: Renewals will no longer be granted once a member reaches a BMI < 25. See additional requirements below (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 PA may be granted. The maximum length of continuous drug therapy is 6 months (waiting period of 6 months before next request).
- **Orlistat:** If the member achieves at least a 10-lb. weight loss, an additional 6-month PA may be granted. The maximum length of continuous drug therapy is 24 months (waiting period of 6 months before next request).
- **Imcivree:** If the member has experienced $\geq 5\%$ reduction in body weight (or $\geq 5\%$ of baseline BMI in those with continued growth potential), an additional 1-year PA may be granted.
- **GLP-1 receptor agonists:** If the member achieves a weight loss of $\geq 5\%$ reduction in body weight compared to the most recent authorization, an additional 6-month PA may be granted.

Check if additional documents will be uploaded.

All approvals are subject to the criteria on this form. Existing authorizations will be honored until renewal.

Provider signature (required)

Date

By signing this document, the physician confirms the above information is accurate and verifiable by member records.

Please include all requested information. Incomplete forms will delay the PA process. Submission of documentation does not guarantee coverage by the Department of Medical Assistance Services.



The completed form may be sent to **Humana Clinical Pharmacy Review:**
Fax: **877-486-2621**