MISSISSIPPI DIVISION OF MEDICAID

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit, PO Box 2480, Ridgeland, MS 39158

☐ **Medicaid Fee for Service**/Gainwell Technologies
Fax to: 1-866-644-6147 Ph: 1-833-660-2402
https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/

☐ **Magnolia Health**/Express Scripts
Fax to: 1-844-205-3387 Ph: 1-866-399-0928
https://www.magnoliahealthplan.com/providers/pharmacy.html

☐ **UnitedHealthcare**/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html

☐ **Molina Healthcare**/CVS Caremark
Fax to: 1-844-312-6371 Ph: 1-844-826-4335
http://www.molinahealthcare.com/providers/ms/medicaid/pages/home.aspx

BENEFICIARY INFORMATION	
Beneficiary ID: ___ ___ ___ - ___ ___ ___ - ___ ___ ___	**DOB: ___ ___ / ___ ___ / ___ ___ ___ ___**
Beneficiary Full Name:	
PRESCRIBER INFORMATION	
Prescriber's NPI:	
Prescriber's Full Name:	**Phone:**
Prescriber's Address:	**FAX:**
PHARMACY INFORMATION	
Pharmacy NPI:	
Pharmacy Name:	
Pharmacy Phone:	**Pharmacy FAX:**

CLINICAL INFORMATION

Requested PA Start Date:_____ **Requested PA End Date:**_____

Drug/Product Requested:_____ **Strength:**_____ **Quantity:**_____

Days Supply:_____ **RX Refills:**_____ **Diagnosis or ICD-10 Code(s):**_____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification.

PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW

Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

Signature required: _____ **Date:** _____

Printed name of prescribing provider:_____

FAX THIS PAGE

Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

Select Covered Obesity Medications PA Criteria

While there are several classes of medications with differing mechanisms of action that are approved by the FDA to treat obesity, Mississippi Medicaid covers selected agents for this condition.

Mississippi Medicaid covers the following anti-obesity agents, subject to this prior authorization criteria:

Preferred:

- Saxenda – age 12 and older
- Wegovy – age 12 and older

Non-preferred:

- Xenical – age 12 and older

The following agents are not covered by Mississippi Medicaid:

Qsymia – *This agent is not rebated through CMS.*
Phentermine, Evekeo/amphetamine – *These agents have not been shown to produce longer-term health benefits in obese and overweight patients.*

Please note: Saxenda and Wegovy are GLP-1 agonists and should be avoided in patients with a history of medullary thyroid carcinoma, multiple endocrine neoplasia syndrome type 2, or a personal or family history of medullary thyroid carcinoma.

Note: Coverage of select medications for the treatment of obesity will be limited to only one covered product at a given time. Mississippi Medicaid will not cover concurrent use of two or more agents for the treatment of obesity.

Saxenda and Wegovy are contraindicated for concomitant use with other GLP-1 agonists (Adlyxin, Bydureon, Byetta, Mounjaro, Ozempic, Rybelsus, Soliqua, Symlin, Trulicity, Victoza, Xultophy) or DPP-4 inhibitors (Janumet, Januvia, Jentadueto, Kazano, Kombiglyze, Nesina, Onglyza, Oseni, Tradjenta).

Mississippi Medicaid does not cover medications for treatment of obesity during pregnancy or for mothers who are breast-feeding.

BMI RESOURCES:

ADULTS

The following **adult** BMI chart is provided for reference, as well as a link to the source on the NIH website: [BMI Chart (nih.gov)]

BMI		25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Height		Body Weight (pounds)																								
in.	ft.in.	Overweight					Obese (class 1)					Obese (class 2)					Obese (class 3)								
58	4'10"	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234
59	4'11"	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242
60	5'0"	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250
61	5'1"	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259
62	5'2"	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267
63	5'3"	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278
64	5'4"	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285
65	5'5"	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294
66	5'6"	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303
67	5'7"	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312
68	5'8"	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322
69	5'9"	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331
70	5'10"	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341
71	5'11"	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351
72	6'0"	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361
73	6'1"	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371
74	6'2"	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381
75	6'3"	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391
76	6'4"	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402

CHILDREN

Determination of BMI in children can be particularly challenging by comparison to adults. As a result, providers are encouraged to reference percentiles and z-scores to evaluate children for appropriate treatment.

The following BMI resource is provided for **children**:

[Growth Charts - CDC Extended BMI-for-Age Growth Charts - Download]

The following criteria encompasses 3 phases of medication treatment of obesity:

- Initial authorization – Patient is evaluated for initiation of treatment. Patient must qualify for treatment based on BMI and/or BMI and other health conditions. A treatment plan is designed by the provider during this phase.
- Reauthorization – Patient is evaluated for continuation of treatment. During this phase, the patient is making progress toward overcoming obesity and/or weight-related comorbidities.
- Maintenance – Patient has reached their goal BMI and treatment shifts toward maintaining the progress they have made.

Prescribing provider's Medicaid ID: _____

The Division of Medicaid reimburses for certain drugs prescribed by a Mississippi Medicaid enrolled prescribing provider licensed to prescribe drugs. Source: 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.332; Miss. Code Ann. §§ 43-13-121, 73- 21-155.

Provider point of contact:
Please provide the name and direct phone number of an office contact person in case the prior authorization reviewer has questions pertaining to this request.

Contact Name: _____ Phone: _____ Ext. _____

I. Initial Authorization:

Duration: Saxenda, Wegovy: 6 months

A. Adults (18 year or older) – *Saxenda or Wegovy*

- ☐ BMI 30 or greater
- ☐ BMI 27 to 29 with at least one weight-related comorbidity:
  - ☐ Hypertension – Confirmed by claims history of antihypertensive medication.
  - ☐ Hyperlipidemia – Confirmed by:
    - Claims history of antihyperlipidemic medication, OR
    - If no medication history, lipid levels: Date of panel . Total Chol. _____ LDL _____ HDL _____ TG _____
  - ☐ Glucose dysregulation – Confirmed by:
    - Diabetes with history of glucose lowering medication OR
    - Pre-diabetes. Defined as:
      - Δ Fasting glucose ≥100, Value _____ Date_____, OR
      - Δ 2-hour OGTT ≥140, Value _____ Date_____, OR
      - Δ HbA1C ≥5.7%, Value _____ Date_____
  - ☐ Obstructive sleep apnea – Confirmed by prior sleep study.
  - ☐ Cardiovascular disease – coronary artery disease, heart failure, prior MI or CVA
  - ☐ Non-alcoholic fatter liver disease (NAFLD)
  - ☐ Other _____
    (attach detailed clinical justification)

B. Children (age 12 - 17 years) – *Saxenda or Wegovy*

Saxenda and Wegovy have differing parameters for use in patients aged 12 -17.

- ☐ Saxenda: Body weight above 60 kg, AND
- ☐ Initial BMI 30 or greater

Wegovy:

- ☐ BMI at ≥ 95th percentile for age and sex (see chart below)

Age (years)	BMI at 95% percentile		Age (years)	BMI at 95% percentile	
	Male	Female		Male	Female
12	24.2	25.2	15	26.8	28.1
12.5	24.7	25.7	15.5	27.2	28.5
13	25.1	26.3	16	27.5	28.9
13.5	25.3	26.8	16.5	27.9	29.3
14	26	27.2	17	28.2	29.6
14.5	26.4	27.7	17.5	28.6	30

*See above CDC link for BMI reference, i.e., z-scores and percentiles, for children.

****REQUIRED FOR ALL PATIENTS:**

Treatment Plan for Qualified Beneficiaries

Patient current BMI: _____

Patient current weight: _____ height:_____

6 Month treatment goal BMI/weight:_____

Other non-scale treatment goals:

_____

Treatment Plan Expected Duration: _____

☐ Yes, ☐ No Has the patient been counseled on appropriate dietary choices and increasing physical activity appropriate to the patient's ability?

☐ Yes, ☐ No Is the obesity treatment plan attached to this form as required?

II. Reauthorization – This phase encompasses the second authorization period.

Patient age: _____

Patient BMI at initial authorization: _____

Patient current BMI: _____ (If at goal or BMI < 25, see III. Maintenance below)

Patient weight at initial authorization: _____

Patient current weight: _____ height: _____

Did the patient reach the initial authorization treatment plan goal? ☐Yes ☐ No

If no, provide clinical justification for continuation of current therapy._____

Next 6 month treatment plan goals: _____

☐ Yes, ☐No Has the patient been counseled on appropriate dietary choices and increasing physical activity appropriate to the patient's ability?

Reauthorization to continue treatment is subject to the following:

☐ Yes, ☐ No Has patient been adherent, as evidenced in paid pharmacy claims? Adherence is defined as 3 claims in the past 105 days.

☐ Yes, ☐ No Is the member tolerating the recommended target dose? See target dosing chart below.

Target Dosing

Agent	Age	Target dose
Saxenda	18+	3mg daily
	12-17	2.4mg daily
Wegovy	18+	1.7mg or 2.4mg weekly
	12-17	1.7mg weekly

- ☐ Weight loss 5% or greater – Approve for additional 6 months.
- ☐ Weight loss 1-4% - *May* be approved 3 months if one of the following applies:
  - ☐ Titration schedule was delayed due to intolerance.
  - ☐ Titration was delayed by hospitalization or illness as documented by evidence of treatment in claims history.
  - ☐ Other non-scale treatment goal progress:

    _____

    _____

  - ☐ 3 month treatment goal if approved:

    _____

    _____
- ☐ Weight loss less than 1% - Deny reauthorization. Consider another covered agent.

III. Maintenance Reauthorization – 6 months

Patient age: _____

Patient BMI at initial authorization: _____

Patient current BMI: _____

Patient weight at initial authorization: _____

Patient current weight: _____ height: _____

Did the patient reach the treatment plan goal from last PA approval? ☐Yes ☐ No

If no, provide clinical justification for continuation of current therapy._____

_____

_____

Next 6 month treatment plan goals: _____

☐ Yes, ☐No Has the patient been counseled on appropriate dietary choices and increasing physical activity appropriate to the patient's ability?

☐ Yes, ☐No Has patient been adherent, as evidenced in paid pharmacy claims? Adherence is defined as 3 claims in the past 105 days.

☐ Yes, ☐ No Is the member tolerating the recommended target dose? See target dosing chart below.

Target Dosing

Agent	Age	Target dose
Saxenda	18+	3mg daily
	12-17	2.4mg daily
Wegovy	18+	1.7mg or 2.4mg weekly
	12-17	1.7mg weekly

☐ Yes, ☐ No Once goal BMI is achieved, has the member maintained a body weight within 15% of goal BMI.