MISSISSIPPI DIVISION OF MEDICAID

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

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

Medicaid Fee for Service/MSCAN/MSCHIP Members
Gainwell Technologies
Fax to: 1-866-644-6147 Ph: 1-833-660-2402
Pharmacy Prior Authorization - Mississippi Division of Medicaid (ms.gov)

Submit your PA requests via the MESA (Medicaid Enterprise System Assistance) provider portal for the most efficient processing
Mississippi Medical Assistance Portal for Providers > Home (ms-medicaid-mesa.com)

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

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Select Covered Obesity Medications PA Criteria

While there are various medications with differing mechanisms of action that are FDA-approved to treat obesity, Mississippi Medicaid covers select agents for this condition. Coverage, subject to prior authorization, is outlined below.

Preferred: Saxenda or Wegovy for ages 12 and older

Non-Preferred: Xenical or orlistat for ages 12 and older

The following agents are not covered by Mississippi Medicaid:

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

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.

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

Note: Saxenda and Wegovy are GLP-1 agonists and should be avoided in patients with multiple endocrine neoplasia syndrome type 2 or a personal or family history of medullary thyroid carcinoma. These agents are contraindicated for concomitant use with other GLP-1 agonists or DPP-4 inhibitors.

HELPFUL RESOURCES:

1. BMI Calculator: https://www.nhlbi.nih.gov/calculate-your-bmi
2. BMI Chart: https://www.nhlbi.nih.gov/sites/default/files/media/docs/bmi_tbl.pdf
3. CDC Growth Charts: https://www.cdc.gov/growthcharts/cdc-growth-charts.htm
4. CDC Extended BMI for Age Growth Charts: https://www.cdc.gov/growthcharts/Extended-BMI-Charts.html

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.

Provider Information and Point of Contact:

Prescribing Provider's Medicaid ID: _____

Office 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 25 to 29 for Wegovy **OR** BMI 27 to 29 for Saxenda 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
  - ☐ Metabolic dysfunction-associated steatotic liver disease [MASLD; formerly known as non-alcoholic fatty liver disease (NAFLD)]
  - ☐ Other _____
    (attach detailed clinical justification)

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

Saxenda:

- ☐ Body weight above 60 kg, AND
- ☐ Initial BMI corresponding to 30 or greater for adults by international cut-offs

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:_____

Date of current weight: _____ Date of current 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: _____ Date of BMI at initial authorization: _____

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

Patient weight at initial authorization: _____ Date of weight at initial authorization: _____

Patient current weight: _____ height: _____

Date of current weight: _____ Date of current 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.

(see next page for additional questions)

☐ Yes, ☐ No Is the member tolerating the recommended target dose of 3 mg daily for Saxenda OR 1.7 mg or 2.4 mg weekly for Wegovy?

- ☐ 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 – 12 months

Patient age: _____

Patient BMI at initial authorization: _____ Date of BMI at initial authorization: _____

Patient current BMI: _____

Patient weight at initial authorization: _____ Date of weight at initial authorization: _____

Patient current weight: _____ height: _____

Date of current weight: _____ Date of current 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 of 3 mg daily for Saxenda OR 1.7 mg or 2.4 mg weekly for Wegovy?

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