



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Weight Loss Agents** (Benzphetamine, diethylpropion, phendimetrazine, phentermine, Wegovy, Zepbound, Saxenda, Orlistat, and Imcivree). Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete.** The 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 – Provider Information

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Note: 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 prescriber

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Please check all that apply:

- Weight Loss-Initial therapy**
- Weight Loss-Continuation of therapy**
- Wegovy- Cardiovascular Risk Reduction sign and submit the form**
- Wegovy- Metabolic Dysfunction-Associated Steatohepatitis (MASH)**
- Zepbound- Moderate to Severe Obstructive Sleep Apnea in adults with Obesity**

5–Diagnosis and Medical History

- Weight Loss Initial Therapy**

Coverage for these medications will be limited to the following:

1. Absence of medical contraindications:

<input type="checkbox"/> History of eating disorder (e.g. anorexia, bulimia)	<input type="checkbox"/> No <input type="checkbox"/> Yes, AND
Stimulant based products	
<input type="checkbox"/> Contraindications to use (i.e., uncontrolled hypertension, hyperthyroidism etc)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Orlistat	
<input type="checkbox"/> History of malabsorption syndromes, cholestasis, pregnancy, and lactation	<input type="checkbox"/> No <input type="checkbox"/> Yes
GLP-1 Inhibitors	
<input type="checkbox"/> History of acute pancreatitis, suicidal behavior or ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. For all others except Imcivree®, additional qualifying criteria are:	
<input type="checkbox"/> Participation in nutritional counseling <input type="checkbox"/> No <input type="checkbox"/> Yes; AND	
<input type="checkbox"/> Participation in physical activity program, unless medically contraindicated	<input type="checkbox"/> No <input type="checkbox"/> Yes, AND
<input type="checkbox"/> Commitment to continue the above weight-loss treatment plan	<input type="checkbox"/> No <input type="checkbox"/> Yes, AND
3. The provider attests that the patient's obesity is disabling and life threatening (i.e., puts the patient at risk for high-morbidity conditions):	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Patient's medical assessment status and individualized weight loss program plan completed within the 60 days prior to the request:	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Accurate height and weight measurements within the last 60 days provided:	
Height _____ Weight _____ BMI _____	
Date _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Copy of the written assessment and individualized and individualized weight-loss program with specific reduced-calorie meal plan, recommended routine physical activity, and behavioral intervention, including lifestyle modification as needed to improve adherence and outcomes is included:	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Summarize previous Weight Loss Plan with Diet and Exercise Components:	

6 – Clinical Criteria

1. Group/Drug Specific Criteria: Anti-obesity-Anorexic and Fat Absorbing agents	
Age:	
<input type="checkbox"/> phentermine: ≥ 17 years old	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> phendimetrazine: ≥ 18 years old	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> phendimetrazine ER caps: ≥ 17 years old	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> orlistat: ≥ 12 years old	<input type="checkbox"/> No <input type="checkbox"/> Yes
Body Mass Index (BMI):	
<input type="checkbox"/> BMI ≥ 30 kg/m ²	<input type="checkbox"/> No <input type="checkbox"/> Yes, OR
<input type="checkbox"/> BMI ≥ 27 kg/m ² , with at least one weight-related comorbidity (select below)	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Coronary Heart Disease <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Type 2 Diabetes	
2. Group/Drug Specific Criteria: Anti-obesity-Anorexic	
Age:	
<input type="checkbox"/> benzphetamine: ≥ 17 years old	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> diethylpropion: ≥ 16 years old	<input type="checkbox"/> No <input type="checkbox"/> Yes
Body Mass Index (BMI):	
BMI ≥ 30 kg/m ²	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Group/Drug Specific Criteria: Anti-Obesity Melanocortin 4 Receptor Agonists	
Age:	
<input type="checkbox"/> Imcivree: ≥ 6 years old	<input type="checkbox"/> No <input type="checkbox"/> Yes
Body Mass Index (BMI):	
<input type="checkbox"/> BMI ≥ 30 kg/m ²	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Prescribed by or in consultation with an endocrinologist or geneticist	<input type="checkbox"/> No <input type="checkbox"/> Yes, AND

- Member has Bardet-Biedl syndrome (BBS) No Yes, OR
 - Member has proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test No Yes, AND
 - Member's genetic variants are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS) No Yes
- 4. Group/Drug Specific Criteria: Anti-Obesity – Incretin Mimetics, FDA indicated for weight loss**

Age:

- Wegovy ≥ 12 years old No Yes
- Saxenda ≥ 12 years old No Yes
- Zepbound ≥ 18 years old No Yes

Body Mass Index (BMI):

- BMI > 40 kg/m², if no applicable risk factors No Yes; OR
- BMI > 37 kg/m² with one or more of the following risk factors (select below) No Yes, AND
- Dyslipidemia Hypertension Type 2 Diabetes, AND
- Member has tried and failed one of the non-GLP1 weight-loss medications(*) No Yes, OR
- Member is intolerant to all non-GLP1 weight-loss medications(*) No Yes, AND
- Member not concurrently on another GLP-1 receptor agonists No Yes
- For an FDA-indicated GLP-1 agonist, the member has tried and failed the selected (*) medication for the duration and outcome listed below: No Yes
- benzphetamine* diethylpropion* phendimetrazine* phentermine*: 3 month trial without a weight loss of 10 lbs No Yes
- orlistat*: 6-month trial without a weight loss of 10 lbs No Yes
- GLP-1 Receptor Agonist: 6-month trial without a body weight reduction of 5% No Yes

Length of Approval Varies (Drug Specific):

Benzphetamine, diethylpropion, phendimetrazine, phentermine: 3 months
 GLP-1 receptor agonists-Wegovy/Zepbound/Saxenda: 6 months
 Orlistat: 6 months
 Imcivree: 4 months

Weight Loss Continuation of Therapy Criteria:

NOTE: Renewals will not be granted once the member reaches a BMI < 25 kg/m²

Check all that apply:

- Is the renewal request made 30 days after the expiration of the last prior authorization approval? No Yes
 If Yes, member is subject to initial weight loss criteria, in Section 5. If No, continue to the next question in this section.
- Is the member's BMI < 25 kg/m² No Yes
 If Yes, the request will be denied. If No, continue to the next question
- Documentation of continued weight loss while on requested therapy is required*. Summarize details No Yes

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- Initial BMI: _____ Initial Weight: _____ Initial Height: _____ No Yes
 - Date of the initial BMI; weight and height measurement _____ No Yes
 - Prior BMI: _____ Prior Weight: _____ Prior Height: _____ No Yes
 - Date of the Prior BMI; Weight and Height measurement _____ No Yes
 - Current BMI _____ Current Weight: _____ Current Height: _____ No Yes
 - Date of the current BMI, weight and height measurement _____ No Yes
 - Other Diagnosis/Risk Factors: _____

Current Medications: _____

- Is there any contraindication for the medication use?

No Yes

Copy of weight-loss treatment plans to include diet and exercise plans, in included

No Yes

***Continuation of Therapy additional information (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 SA may be granted. 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 SA may be granted. Maximum length of continuous drug therapy is 24 months (waiting period of 6 months before next request).
- **GLP-1 Receptor Agonists** – If the member achieves a weight loss of at least 5% from the last authorization, an additional 6-month SA may be granted.

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 SA may be granted.

Wegovy for Cardiovascular Protection

Length of approval: Initial- 6 months Continuation-12 months

Initial Criteria:

- Prescriber is a cardiologist or vascular specialist No Yes, AND
- Member is 45 years of age or older No Yes, AND
- Medication is prescribed by a cardiologist or vascular specialist No Yes, AND
- The member has a clinical history of one of the following (select what applies): No Yes
 - Myocardial infarction (MI), defined as cardiac biomarkers, an electrocardiogram, or cardiac imaging; OR
 - Stroke, defined as neurological dysfunction because of a hemorrhage or infarction; OR
 - Peripheral artery disease, as defined by intermittent claudication with ankle-brachial index less than 0.85 at rest, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; AND
- The member has not had a MI, stroke, transient ischemic attack, or hospitalization for unstable angina in the last 60 days; No Yes, AND
- The member has a BMI ≥ 27 kg/m² No Yes, AND
- The provider attests that the member received individualized healthy lifestyle counseling No Yes, AND
- The member does not have a previous diagnosis of diabetes No Yes, AND
- The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome No Yes

Continuation of therapy: Wegovy for Cardiovascular Protection

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- The member continues to meet the initial criteria No Yes
 - The member is being treated with a maintenance dosage of the requested drug No Yes

Wegovy for Metabolic Dysfunction-Associated Steatohepatitis (MASH)

Length of approval: Initial- 6 months Continuation-12 months

- Therapy is prescribed by or in consultation with a hepatologist, gastroenterologist, or other provider specialized in management of liver disease No Yes, AND
- The member is 18 years of age or older No Yes, AND
- The member's baseline or recent liver biopsy demonstrates clinically significant MASLD (metabolic dysfunction-associated steatotic liver disease) as evidenced by at least ONE of the following: No Yes, AND
 - Histological evidence of MASH; OR
 - NASH Clinical Research Network score consistent with fibrosis stage F2 or F3; OR
 - Nonalcoholic fatty liver disease activity score ≥ 4 with a score of ≥ 1 in each: steatosis, lobular inflammation, and hepatocyte ballooning.
- The member has a BMI ≥ 18.5 kg/m² No Yes, AND
- The provider attests that the member received individualized healthy lifestyle counseling No Yes, AND
- The member does not have an A1C of $>9.5\%$ No Yes, AND

- The member does not have known or suspected excessive consumption of alcohol No Yes; AND
- The member does not have hepatic decompensation or a MELD score of >12 at screening No Yes, AND
- The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome. No Yes, AND
- The member is not concurrently on another GLP-1 receptor agonist No Yes
- Check if additional documents are being furnished

Continuation of therapy: Wegovy for Metabolic Dysfunction-Associated Steatohepatitis (MASH)

- The member has experienced clinical improvement on the requested medication No Yes, AND
- The member is being treated with a maintenance dosage of the requested drug No Yes

Zepbound for Moderate to Severe Obstructive Sleep Apnea in adults with Obesity

Length of approval: Initial- 6 months Continuation-12 months

Initial Criteria:

- The member is 18 years of age or older No Yes, AND
- Medication is being prescribed by a sleep apnea specialist, pulmonologist, otolaryngologist (ENT), neurologist No Yes, AND
- The requesting provider manages the member's obstructive sleep apnea No Yes, AND
- The member has moderate to severe Obstructive Sleep Apnea (OSA), as diagnosed by polysomnography with an apnea-hypopnea index (AHI) ≥ 15 events per hour No Yes, AND
- The member's BMI ≥ 30 kg/m² No Yes, AND
- The member is currently on, or has tried, failed, or there is documented evidence of being unable to tolerate continuous positive airway pressure therapy (CPAP) through an adequate trial of CPAP use for ≥ 4 hours per night on $\geq 70\%$ of nights for two or more months. No Yes, AND
- The member participated in a weight loss treatment plan (e.g. nutritional counseling, an exercise regimen, and calorie restricted/fat restricted diet) in the past 6 months and will they continue to follow this treatment plan while taking an anti-obesity medication for obstructive sleep apnea No Yes, AND
- The member does not have craniofacial abnormalities that may affect breathing No Yes, AND
- The member does not have a diagnosis of central or mixed sleep apnea or Cheyne-Stokes respiration No Yes, AND
- The member does not have pancreatitis, acute suicidal behavior/ideation, or gastroparesis, is the member using prokinetic drugs (e.g., metoclopramide), or does the member have a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome No Yes, AND
- The member will not be using Zepbound concurrently with other GLP-1 receptor agonists No Yes, AND
- The provider attests and has submitted documentation of the following:
 - polysomnography conducted within the last 12 months, AND
 - weight loss treatment plan within the past 6 months No Yes

Continuation of therapy- Zepbound for Moderate to Severe Obstructive Sleep Apnea in adults with Obesity

- The member continues to meet the initial criteria No Yes, AND
- The member is treated with a maintenance dosage of the requested drug No Yes, AND
- The member experienced improvement of OSA symptoms through documented evidence provided No Yes, AND

7 – Provider 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.

Provider Signature:

Date:

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