Medication Prior Authorization Form
Fax to 1-866-240-8123

Saxenda (Liraglutide)

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Drug Name	Drug Strength	Requested Quantity	Requested Day Supply
			☐ 30 days ☐ 90 days ☐ Other: _____
Directions			
Diagnosis			

Clinical Information:

1. Will the member use the requested medication in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity (for example, nutritional counseling, participation in a comprehensive weight management program)?

   ☐ **Yes** ☐ **No**

2. Please specify how long (in months) this member has actively participated in a lifestyle modification program that encourages both a reduced calorie diet and increased physical activity (for example, nutritional counseling, participation in a comprehensive weight management program) **prior** to initiating therapy with the requested medication:

   _____ months

   ***Please attach documentation to support the answers to questions 1 and 2.**
   Acceptable forms of documentation are listed below.
   One from each category is required.

   Diet
   - Provider chart notes detailing specific dietary adjustments and/or calorie deficit
   - Recurring receipts for a subscription to a lifestyle modification program, such as Noom, Weight Watchers, Vida, Lark, Signos, Wondr, Livongo, Omada, Newtopia, Virta, plan sponsored coaching programs such as My Weight Management Journey or Penn State Health obesity medicine institute (e.g., monthly, provided for each month)
   - Dietary log maintained by member detailing specific diet and/or calorie deficit
   - Recurring appointments for private nutritional counseling or medical nutrition therapy (for example, receipt or chart documentation provided monthly)

   Physical Activity
   - Provider chart notes specifying type, duration, and frequency of physical activity
   - Recurring receipts for a gym membership (for example, monthly, provided for each month) and notes specifying type, duration, and frequency of physical activity
   - Summary report from a wearable device specifying frequency of physical activity (for example, elevated heart rate for over 20 minutes for at least 3 times a week for a month)
   - Recurring appointments with a personal trainer (for example, receipt provided monthly) and notes specifying type, duration, and frequency of physical activity)

3. Please list any weight-related comorbidities this member has, if applicable:
   ***Please attach documentation (for example, chart notes) to support this information.**

   _____

   _____

4. Does the member have a diagnosis of prediabetes?

   ☐ **Yes** ☐ **No**

   If yes:

   a. Was the member's diagnosis of prediabetes confirmed by any of the following tests within the past 6 months?
      *Please select **ALL** that apply:*

      ☐ An A1c of 5.7% to 6.4%

      ☐ A fasting plasma glucose (FPG) of 100 mg/dL to 125 mg/dL

      ☐ An oral glucose tolerance test (OGTT) of 140 to 199 mg/dL

      ☐ None of the above

      ***If prediabetes was confirmed by any of these tests, please attach documentation (for example, chart notes) to support this information.**

5. Does the member have a diagnosis of type 2 diabetes mellitus?

☐ **Yes** ☐ **No**

6. Does the member have cardiovascular disease (specifically, prior stroke, prior myocardial infarction, or peripheral arterial disease)?

☐ **Yes** ☐ **No**

***If yes, please attach documentation (for example, chart notes) to support this information.**

7. Please provide any other medications that the member has tried and failed with dates of therapy, if applicable:

Previous weight loss medications (for example, Contrave, Wegovy, Qsymia, Xenical, Zepbound, previous Saxenda (Liraglutide) therapy, etc)	**Dates of therapy**

8. Please provide the member's **baseline** (prior to therapy with the requested medication or any other current weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (for example, chart notes) to support above information.**

9. Only fill out this section for members currently on a weight loss medication.

- Which weight loss medication is the member currently taking? _____
- How long has the member been on this medication?_____
- Please provide the member's **current** (while on therapy with the requested medication or other weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (for example, chart notes) to support above information.**

10. Will the member be using the requested medication with another glucagon-like peptide-1 receptor agonist or glucagon-like peptide-1 receptor agonist combinations?

☐ **Yes** ☐ **No**

11. Has the member experienced therapeutic intolerance or contraindication to Zepbound (specifically, documented severe side effects from Zepbound that were not resolved by diet modification or dose de-escalation and are not anticipated to occur with the requested medication OR documented allergic reaction or hypersensitivity to Zepbound)?

☐ **Yes** ☐ **No**

12. Is the requested medication being prescribed at a dose of 2.4 mg or 3 mg daily?

☐ **Yes** ☐ **No**

If **No**:
Will the requested medication be titrated to a dose of 2.4 mg or 3 mg daily?

☐ **Yes** ☐ **No**

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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