Aetna Better Health® of Virginia Request Form Weight Loss Management Fax back to 1-855-799-2553

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

MEMBER INFORMATION	
Last Name:	First Name:
Medicaid ID Number:	Date of Birth:
Gender: Male Female	Weight in Kilograms:
PRESCRIBER INFORMATION	
Last Name:	First Name:
NPI Number:	
Phone Number:	Fax Number:
DRUG INFORMATION	
All weight loss medications will require a PA, which is	nclude, but are not limited to, the following:
☐ Adipex-P®/Suprenza™ (phentermine)	Alli®/Xenical® (orlista)
Bontril®/Bontril PDM® (phendimetrazine)	Contrave® (bupropion SR/naltrexone SR)
☐ Didrex®/Regimex® (benzphetamine)	☐ Imcivree™ (setmelanotide)
Qsymia® (phentermine/topiramate ER)	Radtue® (diethylpropion)
Saxenda® (liraglutide)	Wegovy™ (semaglutide)
Drug Name/Form:	
Strength:	
Dosing Frequency:	
Length of Therapy:	
Quantity per Day:	
(Form continued on next page.)	

Aetna Better Health® of Virginia Request Form: Weight Loss Management

Member's Last Name:										Member's First Name:													
DI	DIAGNOSIS AND MEDICAL INFORMATION																						
	the physician does not have the necessary information, the request will be denied and the fax form																						
	-	_			nforma						-												
Со	verag	ge foi	these	e med	dicatio	ns w	ill be	e lim	ited	to th	e f	ollo	wing	:									
1.	Bod	y ma	ss inde	ex (BI	VII) red	quire	men	ts:															
	BMI ≥ 30, if no applicable risk factors																						
	BMI ≥ 27 with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type II diabetes																						
	BMI ≥ 30 or ≥ 95th percentile on pediatric growth chart (Imcivree™)																						
	Body weight above 60 kg and an initial BMI corresponding to 30 kg/m ² for adults (obese) by international cut-offs (Saxenda® in pediatric patients 12 years of age and older)																						
2.	Age	resti	riction	s:																			
	Covered only for members 16 years of age or older																						
	Saxenda only covered for members 12 years of age or older																						
		Imciv	ree or	nly co	vered	for m	nemb	oers	6 yea	ars o	f ag	ge or	olde	er									
		Wego	vy on	ly cov	ered f	for m	emb	ers	18 ye	ears o	of a	ge o	r old	er									
3.	Initi	ial Re	quest	Requ	uireme	nts:																	
		No co	ntrair	ndicat	ions to	o use	; AN	D															
		No m	alabso	orptic	n synd	drom	es, c	hole	estasi	s, pr	egn	ancy	, an	d/or	lacta	ition;	ANI)					
		No hi	story	of an	eating	diso	rder	(e.g	g., and	orexi	a, k	oulin	nia);	AND									
		calori	ie/fat-	restri	of a wo icted d mcivre	liet) i	n the			•											_		
	:	Speci	fic to	Imciv	ree™	ONLY	,																
		Pı	rescrib	ed b	y or in	cons	ultat	tion	with	an e	ndo	ocrin	olog	ist o	rgen	eticis	st ; A l	ND					
					proop eptor (•			•							kexii	า typ	e 1 (F	°CSK1	L),
			lembe gnifica	_	enetic (VUS)	varia	nts a	ire ii	nterp	rete	d a	s pat	hoge	enic,	likely	y pat	hoge	nic, (or of	unce	ertain	l	
(Fo	orm c	ontin	ued o	n nex	t page	.)																	

C10645-A 10/2022 Effective 1/1/2023

Member's Last Name:											Men	nber	's Fir	st Na	ame:									
4.	The	writ	ten	docu	men	tatio	n m	ust i	nclu	de:														
	Current medical status including nutritional or dietetic assessment																							
 Current therapy for all medical conditions (including obesity), identifying specific treatments included medications 														ling										
	Current accurate height and weight measurements																							
	☐ No medical contraindications to use a reversible lipase inhibitor (Xenical®)																							
	Current weight loss plan or program including diet and exercise plan																							
		No c	hron	іс ор	ioid	use c	onci	urrei	ntly	with	Con	trav	ve®											
		Men	ber	not c	oncu	urren	tly c	n Vi	ctoz	a or	Ozer	npi	c or	othe	GLF	P-1 in	hibit	ors (Saxe	nda®	⁾ and	We	govy	тм)
5.	Leng	gth o	of Au	thor	izatio	on:																		
		nitia	ıl red	quest	:: Vai	ries (drug	g spe	cific	:)														
		•	Ber	zphe	etam	ine, d	dieth	ıylpr	opio	n, pł	nend	ime	etraz	ine, _l	ohen	term	nine,	Qsyr	nia, (Contr	ave®	-3	mon	ths
		•	We	govy	тм — 6	6 mo	nths																	
		•	Alli	®/Xer	nical	® – 6	mor	nths																
		•	Sax	enda	® an	d Im	civre	е™ -	- 4 n	nont	hs													
		Rene	wal	requ	ests	: Var	ies (drug	spe	cific))													
		_	Bor	znho	tom	ino (diatl	avla:	oni	an n	hon	dim	otra	zino.	nho	ntor	mina	ıf.	tha n	aaml	oor o	chio	,000	+

- 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. Maximum length of continuous drug therapy is 6 months (waiting period of 6 months before next request).
- **Qsymia**® If the member achieves a weight loss of at least 3% of baseline weight, an additional 3-month PA may be granted. For a subsequent renewal, member must meet a weight loss of at least 5% of baseline weight to qualify for an additional 6-month PA. Maximum length of continuous drug therapy is 12 months (waiting period of 6 months before next request).
- Alli®/Xenical® If the member achieves at least a 10 lb. weight loss, an additional 6-month PA
 may be granted. Maximum length of continuous drug therapy is 24 months (waiting period of 6
 months before next request).
- **Contrave**® Approve for 6 months with each renewal if weight reduction continues.
- Saxenda® If the member achieves a weight loss of at least 4% of baseline weight, an additional 6-month PA may be granted as long as weight reduction continues.
- Imcivree™ If the member has experienced ≥ 5% reduction in body weight (or ≥ 5% of baseline BMI in those with continued growth potential), an additional 1 year PA may be granted.
- Wegovy™ If the member achieves a weight loss of at least 5% of baseline weight, an additional 6 month PA may be granted.

Note – Renewal PA requests will **NOT** be authorized if the member's BMI is < 24. (Form continued on next page.)

Member's Last Name:											Member's First Name:										
6.	Asses	ssment	:																		
7.	Othe	r Diagn	oses/R	isk Fac	tors:																
8.	Current Medications:																				
9.	Current BMI: Height:																				
	Iactat Ye If YES		e descr	No ibe: of prev	ious	weig	ght lo														
Ву	Prescriber Signature (Required) By signature, the physician confirms the above information verifiable by member records.										on i	is acc	urate			Date					
		clude A on of do	-				-		-				l dela	y the	e PA	proce	ess.				