Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

GLP-1's for Weight Management

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name:_____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Request (Wegovy, Saxenda, and Zepbound):

1.Please list the members' baseline weight and BMI. Weight _____ Date _____ BMI _____ Date_____

2. Is the member 18 years or age or older? ☐ **Yes** ☐ **No**

2a. Does the member have a BMI greater than or equal to 30 kg/m2? ☐ **Yes** ☐ **No**

2b. Does the member have a BMI greater than or equal to 27 kg/m2? ☐ **Yes** ☐ **No**

2b-i. Does the member have at least one weight-related comorbidity/risk factor/complication (i.e. hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? ☐ **Yes** ☐ **No List** _____

3. Is the member between 12-17 years or age? ☐ **Yes** ☐ **No**

3a. Does the member have a BMI greater than or equal to the 95th percentile for age and sex? ☐ **Yes** ☐ **No**

3b. Does the member have a BMI greater than or equal to 30 kg/m2? ☐ **Yes** ☐ **No**

3c. Does the member have a BMI greater than or equal to the 85th percentile for age and sex? ☐ **Yes** ☐ **No**

3c-i. Does the member have at least one weight-related comorbidity/risk factor/complication (i.e. hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? ☐ **Yes** ☐ **No List** _____

4. Is the member age 45 years of age or older? ☐ **Yes** ☐ **No**

4a. Does the member have a BMI greater than or equal to 27 kg/m2? ☐ **Yes** ☐ **No**

4a-i. Does the member have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral disease? ☐ **Yes** ☐ **No List** _____

5. Is the member currently on and will the member continue lifestyle modification including structured nutrition and physical activity, unless physical activity is not clinically appropriate at the time GLP1 therapy commences? ☐ **Yes** ☐ **No**

6. Will the member be using the requested agent with another GLP-1? ☐ **Yes** ☐ **No**

7. Does the member have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? ☐ **Yes** ☐ **No**

Continuation Request (Wegovy, Saxenda, and Zepbound):

8. Has the member previously been approved for the requested agent through NC Medicaid's PA process? ☐ **Yes** ☐ **No**

9. Member's baseline and current weight. Baseline Wt. _____Date _____Current Weight _____ Date_____

10. Member's baseline and current BMI. Baseline BMI _____ Date _____Current BMI_____ Date_____

11. Is the member continuing a current weight loss course of therapy? ☐ **Yes** ☐ **No**

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12. **Ages 18 and older**- Has the member lost a total of 5% of pretreatment weight and is maintaining the 5% weight loss?
☐ **Yes** ☐ **No** Baseline Weight_____ Current Weight_____
13. **Ages (>12 to <18 years)** –Has the member had >4% reduction in baseline BMI and is maintaining the weight loss?
☐ **Yes** ☐ **No** Baseline Weight_____ Current Weight_____
14. Does the member have a documented weight loss that is deemed to be a significant reduction from BMI per the prescriber and the weight loss is maintained, yet the 5% (for adults) and 4% (for adolescents) is not met? ☐ **Yes** ☐ **No**
Rationale_____
15. Is the member currently on and will continue lifestyle modification including structured nutrition and physical activity?
☐ **Yes** ☐ **No**
16. Will the member be using the requested agent with another GLP-1? ☐ **Yes** ☐ **No**
17. Does the member have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? ☐ **Yes** ☐ **No**

Request for Non-Preferred Drug (Saxenda, and Zepbound):

1. Failed preferred drug(s). List preferred drugs failed: _____
1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____ _____
2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
_____ _____ _____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. Age specific indications. Please give patient age and explain: _____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____
_____
_____

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.