DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Request for Medication Prior Authorization

GLP-1 Agonist for Weight Management, MASH or Prevention of MACE

Submit request via the DMAP Provider Portal or by fax: 1-302-454-0224

The purpose of this record is for payment purposes. The member's medical record must substantiate the information provided on this form and compare for consistency. Delaware Medical Assistance Program (DMAP) reserves the right to request chart records to confirm the information provided below.

General Information

Member Name: _____ DOB: _____

Medicaid ID Number: _____ Date of Request: _____

Practitioner Name: _____ NPI: _____

Office Phone Number: _____ Office Fax Number: _____

Diagnosis with ICD-10: _____

Requested Medication with Strength: _____

Proposed Directions: _____ Proposed Duration: _____

Is Brand Name Medication Medically Necessary? ☐ Yes* ☐ No *if yes, MedWatch Form 3500 is required

Required Attachments

☐ Member's relevant medical records and/or pharmacy profile.

☐ Appropriate baseline diagnostic and safety biopsy, laboratory, and/or noninvasive test results

Coverage

Therapy coverage must be for an approved U.S. Food and Drug Administration (FDA) indication as found in the FDA approved prescribing information. All other indications will be considered experimental and may not be covered. For consideration for an unapproved off-label use, two peer reviewed articles must be provided that demonstrate both safety and efficacy for the therapy prescribed.

To receive authorization for a glucagon-like peptide-1 (GLP-1) agonist, a member must meet the general criteria for the requested indication, as outlined below. For all GLP-1 agonists, the agent must be used in conjunction with a reduced calorie diet and increased physical activity. Supporting documentation with appropriate disease-specific diagnostic and safety laboratory results must be submitted for review. Additionally, the member cannot have a contraindicated condition/disease(s) and cannot currently be on another GLP-1 agonist and/or a contraindicated medication(s).

Initial Criteria – Weight Loss

- Member must have obesity as defined below.
  - For adult member – body mass index (BMI) ≥ 30 kg/m^2
  - For pediatric member – BMI ≥ 95^{th} percentile for age and weight

OR

- Member must be overweight as defined as a BMI between ≥ 27 kg/m^2 and < 30 kg/m^2 and have at least one (1) co-morbid condition listed below.
    - Cardiovascular disease (CVD)
    - Heart failure
    - Chronic kidney disease stage 3a or above
    - Hypertension
    - Hyperlipidemia
    - Peripheral artery disease (PAD)
    - Moderate to severe obstructive sleep apnea (OSA) defined as apnea–hypopnea index >15 without central or mixed sleep apnea
    - Type 2 diabetes

Initial Criteria – MASH

- Requested agent must be prescribed by or in conjunction with a hepatologist or gastroenterologist
- Member must have moderate to advanced liver fibrosis (consistent with stages F2 to F3) confirmed by one (1) of the following:
    - Biopsy
    - Non-invasive tests (e.g., FibroScan or MRE + MRI-PDFF)
- While obesity is a risk factor for MASH, a BMI ≥ 27 kg/m^2 is not a requirement for approval

Initial Criteria – Prevention of Major Adverse Cardiovascular Events (MACE)

- Member must have a BMI ≥ 27 kg/m^2
- Member must have established CVD

Therapy Information

Previous Therapy (to include dates and/or results):

_____

_____

Current / Proposed Therapy:

_____

_____

Authorization Information:

Current Weight: _____ ☐ Pounds (lb) ☐ Kilograms (kg); Date Measured: _____
Current Height: _____ ☐ Inches (in) ☐ Centimeters (cm)
Current BMI: _____ kg/m^2

If request is for weight loss and BMI is between ≥ 27 kg/m^2 and < 30 kg/m^2, clinical co-morbid diagnosis with ICD-10 required: _____

For All Prior Authorizations:

Are the dosage, frequency, and age within the FDA approved range?	☐ Yes	☐ No
Has documentation of appropriate and disease-specific diagnostic and safety laboratory results with dates performed been provided?	☐ Yes	☐ No
Has the member been placed on an appropriate reduced calorie diet?	☐ Yes	☐ No

Has the member increased their physical activity?	☐ Yes	☐ No
Is the member currently on another GLP-1 agonist?	☐ Yes	☐ No
Does the member have any disease or medication contraindication(s) with the requested GLP-1 agonist?	☐ Yes	☐ No
For MASH only – Is the requested agent prescribed by, or in consultation with a specialist experienced in the treatment of MASH? Name of consulting provider: _____ NPI of consulting provider: _____	☐ Yes	☐ No
For a non-preferred agent request – have appropriate preferred medications been utilized and are results documented in the provided medical records and on this form?	☐ Yes ☐ No	☐ N/A
Is a pharmacy claims history or pharmacy profile included in the records provided?	☐ Yes	☐ No

For Re-Authorization Only:

For weight loss, has the member lost the required minimal amount of weight?	☐ Yes	☐ No
For MASH or prevention of MACE, does the member derive a clinical benefit with the requested agent?	☐ Yes	☐ No
For MASH or prevention of MACE, does the member require ongoing therapy with the requested agent as part of the member's treatment plan?	☐ Yes	☐ No

Required Justification/Additional Information

In the space provided below, provide any additional justifications as required

_____

_____

_____

_____

_____

Initial Authorization

If the member meets the above coverage requirements and requested documentation is provided, then Prior Authorization will be granted for up to 6 months in ≤ 30-day supplies, of an authorized GLP-1 agonist agent at a standard dose.

Re-Authorization Criteria

- For Weight Loss:
  - The prescriber must provide documentation that a substantial, minimal amount of weight loss has occurred. The minimum weight loss that must occur is ≥ 5% for adults and ≥ 4% for adolescents of the baseline weight.
  - If required documentation has been provided and adequate weight loss has occurred or has been maintained, then Prior Authorization will be granted for 6 months in ≤ 90-day supplies of an authorized GLP-1 agonist agent at a standard dose.
  - If at any time more than 50% of what has been lost is regained or if total weight loss from the baseline is ever < 5% for adults or < 4% for adolescents, then the prior authorization for a GLP-1 agonist, as determined by the DMAP, may not be renewed for at least one year.

- For MASH or prevention of MACE:
  - For members meeting initial approval criteria, resubmission of initial coverage documentation is not required.
  - Continued coverage may be approved when the prescriber attests to the following:
    - The member continues to derive clinical benefit with the requested agent, and
    - The member requires ongoing therapy with the requested agent as part of the member's treatment plan
  - If the member meets the above coverage requirements, then Prior Authorization will be granted for 6 months in ≤ 90-day supplies of an authorized GLP-1 agonist agent at a standard dose.