MASSACHUSETTS

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Pharmacy Medical Policy
Drugs for Weight Loss

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Policy Number: 572

BCBSA Reference Number: None

Related Policies

- Policy #621A Quality Care Dosing guidelines

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

Drug	Formulary Information
	Standard
	Formulary Status
Contrave ® (naltrexone / bupropion)	PA Required
Imcivree ™ (setmelanotide**)**	PA Required
Saxenda ® (liraglutide)	PA Required
Wegovy ™ (semaglutide)	PA Required

Initiation of **Contrave®** (naltrexone HCl and bupropion HCl), **Saxenda®** (liraglutide) or **Wegovy™** (semaglutide) may be approved for up to 20 weeks when **all** of the following criteria are met:

- Members 18% years of age or older**, AND**
- As an adjunct to a reduced-calorie diet and increased physical activity, **AND**
- For chronic weight management in patients,
  - with an initial body mass index (BMI) of ≥ 30 kg/m^2 (obese), **OR**
  - ≥ 27 kg/m^2 (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes)

AND

- Documentation that the member has been and is currently following a dietary and behavior modification programs for weight loss.

% **Saxenda®** (liraglutide) Is FDA approved for 12 years of age or older and body weight above 60 kg.

Continuation of therapy for **Contrave®** (naltrexone HCl and bupropion HCl), **Saxenda®** (liraglutide) or **Wegovy™** (semaglutide) may be approved for up to an additional 6 months of therapy when **all** of the following criteria are met:

- Demonstrate significant weight loss*, after initiation of therapy, **AND**
- Adhering to a reduced-calorie diet, **AND**
- Adhering to increased physical activity, **AND**
- Third party documentation, if applicable, is included with the request for continuing treatment, **AND**

***Note**: **Contrave®** (naltrexone \ bupropion) requires documented weight loss of at least 5% of baseline body weight after the initiation of treatment (first 12 weeks of treatment), **OR** must demonstrate continued weight loss, **OR** maintain the plateau weight achieved with diet, exercise.

Saxenda® (liraglutide) requires documented weight loss of at least 4% of baseline body weight after the initiation of treatment (first 16 weeks of treatment), **OR** must demonstrate continued weight loss, **OR** maintain the plateau weight achieved with diet, exercise treatment.

Wegovy™ (semaglutide) requires documented weight loss of at least 4% of baseline body weight after the initiation of treatment (first 16 weeks of treatment), **OR** must demonstrate continued weight loss, **OR** maintain the plateau weight achieved with diet, exercise treatment and requires the member to be on the 2.4mg dose.

Initiation of **Imcivree** ™(setmelanotide) may be approved for up to 4 months when **all** of the following criteria are met:

- Diagnosis of obesity, defined as:
  - Adult patients: BMI of ≥30 kg/m2
    OR
  - Pediatric patients: ≥95th percentile using growth chart assessment

AND

- Members 6 years of age or older,

AND

- Obesity is due to a homozygous or presumed compound heterozygous variant in at least one of the following genes, confirmed by genetic testing:
  - Proopiomelanocortin (POMC)
  - Proprotein convertase subtilisin/kexin type 1 (PCSK1)
  - Leptin receptor (LEPR)

AND

- Documentation of genetic testing demonstrating that the variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic, or Variants of Uncertain Significant (VUS).

Continuation of therapy for **Imcivree** ™(setmelanotide)) may be approved when all of the following criteria are met:

First Renewal Criteria for Consideration for Imcivree

- Documentation of response to therapy, as evidenced by:
  - At least a 5% reduction in baseline body weight **OR**
  - At least a 5% reduction in baseline BMI for patients with continued growth potential
- Demonstration of treatment adherence
  Approvals may be granted for up to 4 additional months

OR

Subsequent Renewal Criteria for Consideration for Imcivree

- Documentation of maintained response to therapy, as evidenced by:
  - Maintenance of at least a 5% reduction in baseline body weight **OR**
  - Maintenance of at least a 5% reduction in baseline BMI for patients with continued growth potential
- Demonstration of treatment adherence

  Approvals may be granted for up to 12 additional months

##Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met

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Coverage Criteria, for initiation and continuation of therapy shall include: Weight, Height, BMI, Weight History, Systolic/ Diastolic BP, For Diabetics HbA1c, Ruled out weight gain due to drug therapy (e.g., anti-psychotics, TZDs, others), Addition of drug therapy is clinically indicated for Member currently adhering to diet modification and exercise program, and pharmacy prescription claims history of treatment for comorbid conditions (e.g., antihypertensive, diabetes, dyslipidemia).

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

We do not cover conditions not listed above.

CPT Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Policy History

Date	Action
1/2022	Updated both initial authorization length and continuation authorization length.
7/2021	Updated to add Wegovy to the policy.
4/2021	Updated to add Imcivree to the policy.
1/2021	Updated to remove Belviq and Belviq XR as FDA withdrew them from the market and update age for Saxenda®.
1/2020	Updated to make Belviq and Belviq XR not covered.
6/2017	Updated address for Pharmacy Operations.
12/2016	Updated to Add Belviq XR®
6/2016	Updated FDA approved Saxenda® dosing.
12/2015	Updated to add Contrave® and Saxenda®.
8/2014	Coding information clarified.
1/2014	Implementation of policy.
9/2013	Pharmacy and Therapeutics Committee review.

References

1. Belviq® [package insert]. Eisai Inc., Woodcliff Lake, NJ 07677
2. Contrave® [package insert]. Takeda Pharmaceuticals America, Inc., La Jolla, CA -2014
3. Saxenda® [package insert]. Novo Nordisk Inc., Plainsboro, NJ –Jan 2015
4. Imcivree® [package insert]. Rhythm Pharmaceuticals, Inc., Boston, MA–Dec 2020
5. Wegovy™ [package insert]. Novo Nordisk Inc., Plainsboro, NJ –June 2021.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf