Print Reset

United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

GLP-1 RECEPTOR AGONISTS FOR OBSTRUCTIVE SLEEP APNEA

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

For initial requests, continue below. For renewal requests, proceed to Length of Authorization. If approved, initial authorizations are granted for 6 months. Renewal authorizations are granted for 12 months.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

- FDA indicated medications only
- Must be prescribed by an otolaryngologist (ENT), neurologist, pulmonologist, or sleep apnea specialist for the member to receive authorization

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member is 18 years of age or older? **AND**

   ☐ Yes ☐ No

2. Is the requesting provider managing the member's obstructive sleep apnea? **AND**

   ☐ Yes ☐ No

3. Does the member have a diagnosis of moderate to severe obstructive sleep apnea (OSA), defined by an apnea-hypopnea index ≥ 15 events/hour and confirmed by polysomnography? **AND**

   ☐ Yes ☐ No

4. Is the member is currently on or has the member tried, failed, or been unable to tolerate continuous positive airway pressure therapy (CPAP) (an adequate trial is defined as CPAP use for ≥ 4 hours per night on ≥ 70% of nights for two or more months)? **AND**

   ☐ Yes ☐ No

   If unable to tolerate CPAP therapy, please explain the intolerance below:

   _____

5. Does the member have a body mass index (BMI) of ≥ 30kg/m^2? **AND**

   ☐ Yes ☐ No

6. Has the member participated in a weight loss treatment plan (e.g. nutritional counseling, an exercise regimen, and calorie restricted/fat restricted diet) in the past 6 months and will they continue to follow this treatment plan while taking an anti-obesity medication for obstructive sleep apnea? **AND**

   ☐ Yes ☐ No

7. Does the member does have craniofacial abnormalities that may affect breathing? **AND**

   ☐ Yes ☐ No

8. Does the member have a diagnosis of central or mixed sleep apnea or Cheyne-Stokes respiration? **AND**

   ☐ Yes ☐ No

9. Is the member using any other GLP-1 product? **AND**

   ☐ Yes ☐ No

10. Does the member have pancreatitis, acute suicidal behavior/ideation, or gastroparesis, is the member using prokinetic drugs (e.g., metoclopramide), or does the member have a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome?

    ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

ATTESTATION AND DOCUMENTATION

☐ Submission of polysomnography conducted within the last 12 months

☐ Submission of weight loss treatment plan within the past 6 months

LENGTH OF AUTHORIZATION

Renewal requests (see additional requirements below):

1. Does the member continues to meet the criteria? **AND**

   ☐ Yes ☐ No

2. Is the member being treated with a maintenance dosage of the requested drug? **AND**

   ☐ Yes ☐ No

3. Is documentation attached verifying that the member has experienced improvement in OSA symptoms?

   ☐ Yes ☐ No

☐ **Attachments**

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826

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