Update on Anti-Obesity Medications (AOM's)

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MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

Objectives

- Compare and contrast anti-obesity medications.
- Appreciate prior authorization criteria.
- Apply selection of a medication to a case.

MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

Adiposity-Based Chronic Disease
"Diabesity"

30-50% of new cases of diabetes are due to obesity

85% of people with diabetes have overweight or obesity

Cameron 2021

Treat Diabetes or Obesity First?

Old Treatment Paradigm
Treat Weight *LAST*

	Dys-lipidemia	HTN	IGT
Monitor	Lipid panels Lipoproteins subsets	Blood Pressure Ambulatory Blood Pressure	Blood sugar Glycosylated hemoglobin distribution
Diet	↓ Total fat ↓ Chol. ↑ Fiber	↓ Sodium ↑ K ++	↓ Sugar Distribute CHO, PRO, Fat
Meds	Statins Fibrates Resins Niacin	Central acting Renal effective Peripherally acting diuretics Thiazide diuretics	Insulin Sulfonylureas Glidizones Absorption agents

	Overweight/Obesity
Monitor	Weight and BMI
Diet	Any diet patient will adhere to
Exercise	150 minutes of moderate-intensity aerobic activity/wk and muscle-strengthening activities on ≥ 2 days/wk
Meds	Orlistat, phentermine, phentermine/topiramate, lorcaserin

New Treatment Paradigm
Treat Weight *FIRST*

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	Dys-lipidemia	HTN	IGT
Monitor	Lipid panels Lipoproteins subsets	Blood Pressure Ambulatory Blood Pressure	Blood sugar Glycosylated hemoglobin distribution
Diet	↓ Sat + trans fat ↑ Omega-3s ↑ MUFA ↓ Simple CHOs ↓ ETOH	DASH Diet ↓ Sodium ↓ ETOH	Glycemic index diet ↑ Fiber Diabetic diet
Meds	Statins Fibrates	ACE Inhibitors ARBs Thiazide diuretics	Metformin Exenatide Liraglutide

Garvey 2016; Apovian 2016

FDA Approved Anti-Obesity Medications

Agents	Mechanism	Effect
Phentermine	Sympathomimetic	Appetite regulation
Phentermine + Topiramate ER (Qsymia)	Sympathomimetic + anticonvulsant (GABA receptor modulation, carbonic anhydrase inhibition, glutamate antagonism)	Appetite regulation
Naltrexone + bupropion SR (Contrave)	Opioid receptor antagonist + Dopamine / norepinephrine reuptake inhibitor	Appetite regulation
Liraglutide (Saxenda)	GLP-1 receptor agonist	Appetite regulation
Semaglutide (Wegovy)	GLP-1 receptor agonist	Appetite regulation
Orlistate (Xenical or Alli)	Pancreatic lipase inhibition	Reduce fat absorption

Anti-Obesity Medications

FDA Approved

- Phentermine
- Diethylpropion
- Phendimetrazine
- Benzphetamine
- Orlistat
- Phentermine/Topiramate
- Naltrexone/Bupropion
- Liraglutide
- Semaglutide

Off Label Use

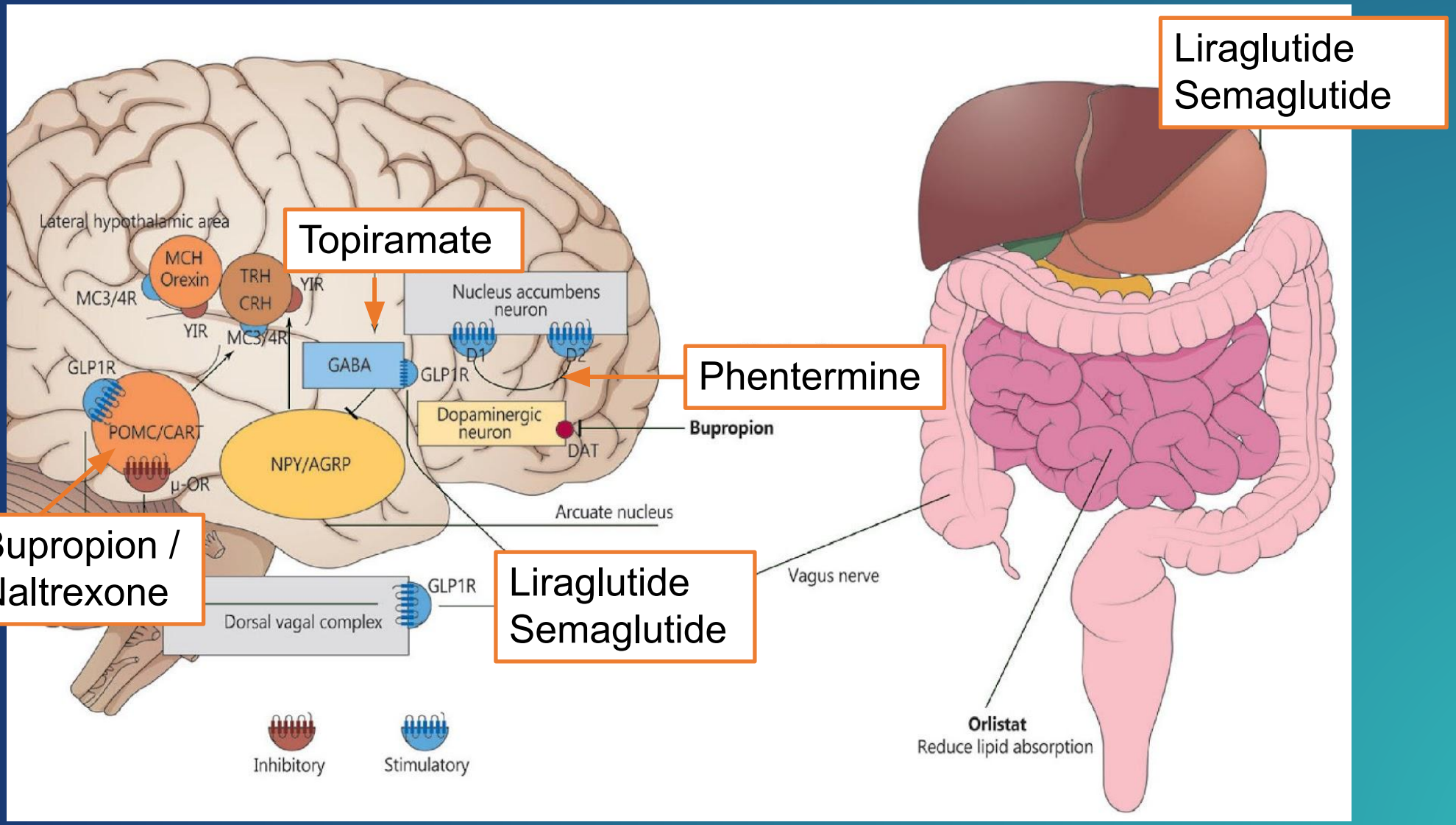
- Metformin
- SGLT2I's
- Pramlintide
- Topiramate
- Zonisamide
- Bupropion
- Naltrexone

Future pipeline …

- Tirzepatide (GLP-1/GIP dual agonist
- Cagrilintide (amylin analog)
- Cagrilintide+ semaglutide
- Bimagrumab (monoclonal Ab)

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

How do Anti-Obesity Medications Work?



Son 2020

Case 1: L.J.

45-year-old female with T2D A1C 11.1

- PMH: CAD, PCI 2019, BMI 45, asthma
- Labs: A1C 11.1, GFR >90, microalbumin (-)
- Had COVID-19 with 50-pound weight gain
- Lost 50 lbs with Weight Watchers
- "I started feeling hungry all the time."

Height 5'3" Weight 260 lb

L.J.'s Medications

- Metformin 1000 mg PO BID
- Glipizide XR 15 mg QD
- Albuterol prn
- ASA 81 po QD
- Atorvastatin 40 po QD
- Fluticasone prn
- Lisinopril 20 mg QD
- Metoprolol XL 50 mg QD

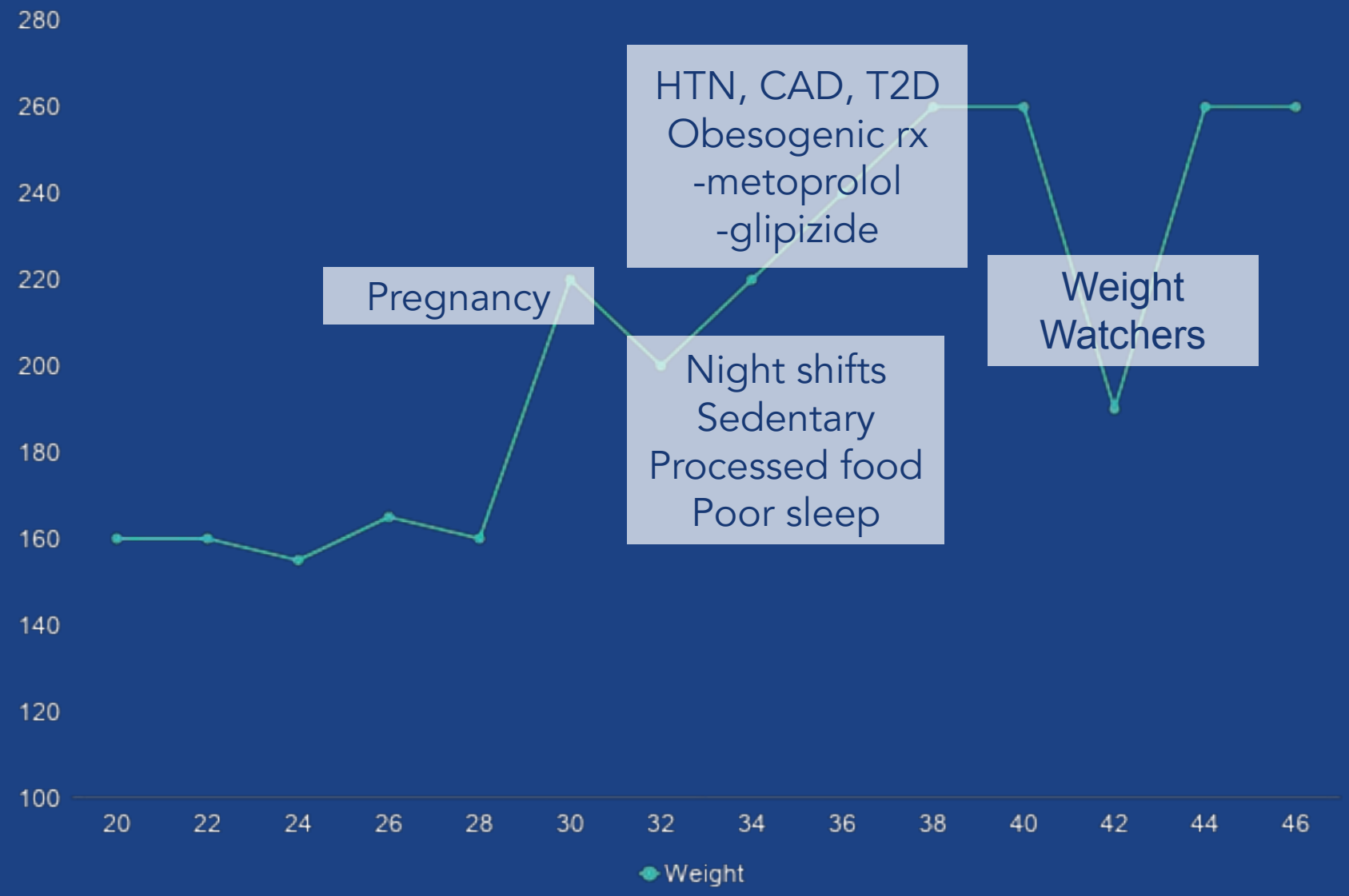
Which medications are obesogenic?

- Metformin 1000 mg PO BID
- Glipizide XR 15 mg QD
- Albuterol prn
- ASA 81 po QD
- Atorvastatin 40 po QD
- Fluticasone prn
- Lisinopril 20 mg QD
- Metoprolol XL 50 mg QD

- Sulfonylureas ~ 2-3 kg
- Metoprolol ~ 1kg

Domecq 2015, Messerli 2007

L.J.'s Weight History



Which AOM would you choose for L.J.?

"Hungry Brain"
Phentermine-
Topiramate

"Emotional Brain"
Bupropion-
Naltrexone

☑

"Hungry Gut"
GLP-1-RA
Liraglutide
Semaglutide

"Slow Burn"
Phentermine

Acosta 2021; icons from Noun project.

Semaglutide 2.4 mg

MOA: increases satiety, decreases gastric emptying.

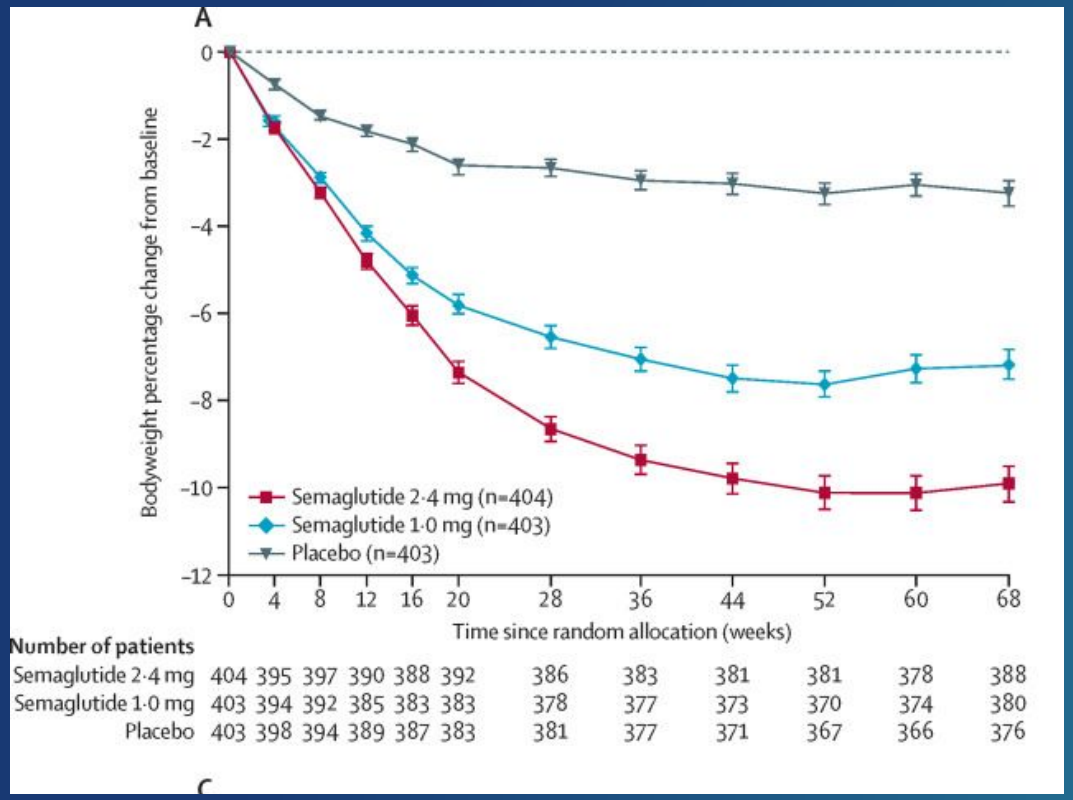
Dose: start at 0.25 mg SQ weekly, titrate monthly to 2.4 mg SQ weekly

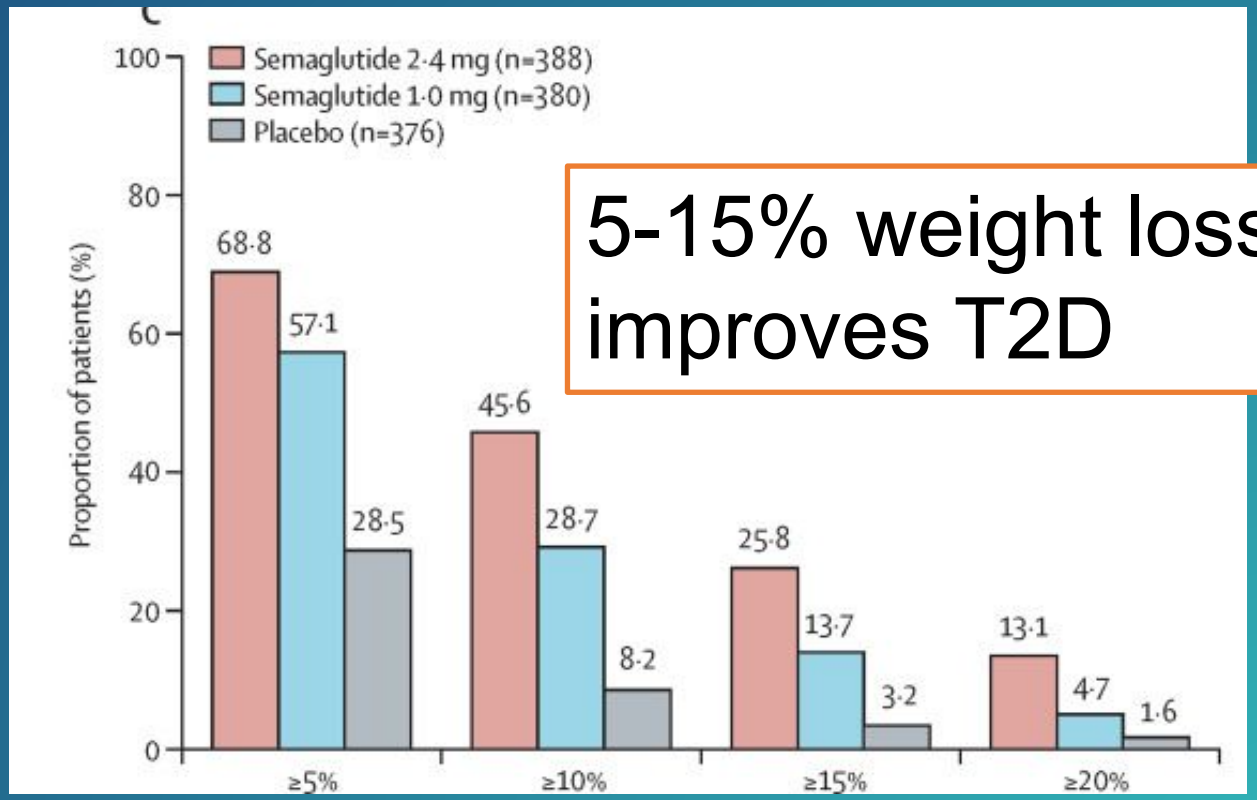
CI's: PMH or FH medullary thyroid cancer, MEN II syndrome, pregnancy or lactation

AE's: commonly, nausea headache, GERD, constipation
rarely, pancreatitis, gallstones, renal impairment, hypoglycemia

Counsel: eat slow, smaller portions, tx nausea, constipation

Obesity Outcomes:
Semaglutide 2.4 mg v. 1.0 mg





5-15% weight loss improves T2D

Davies 2021

GLP-1 Receptor Agonists

Liraglutide (Saxenda)

- 0.6 mg SQ daily X1wk
- 1.2 mg SQ daily X1wk
- 1.8 mg SQ daily X1wk
- 2.4 mg SQ daily X1wk
- 3.0 mg SQ daily

Semaglutide (Wegovy)

- 0.25 mg SQ daily X4wk
- 0.5 mg SQ daily X4wk
- 1.0 mg SQ daily X4wk
- 1.7 mg SQ daily X4wk
- 2.4 mg SQ daily X4wk

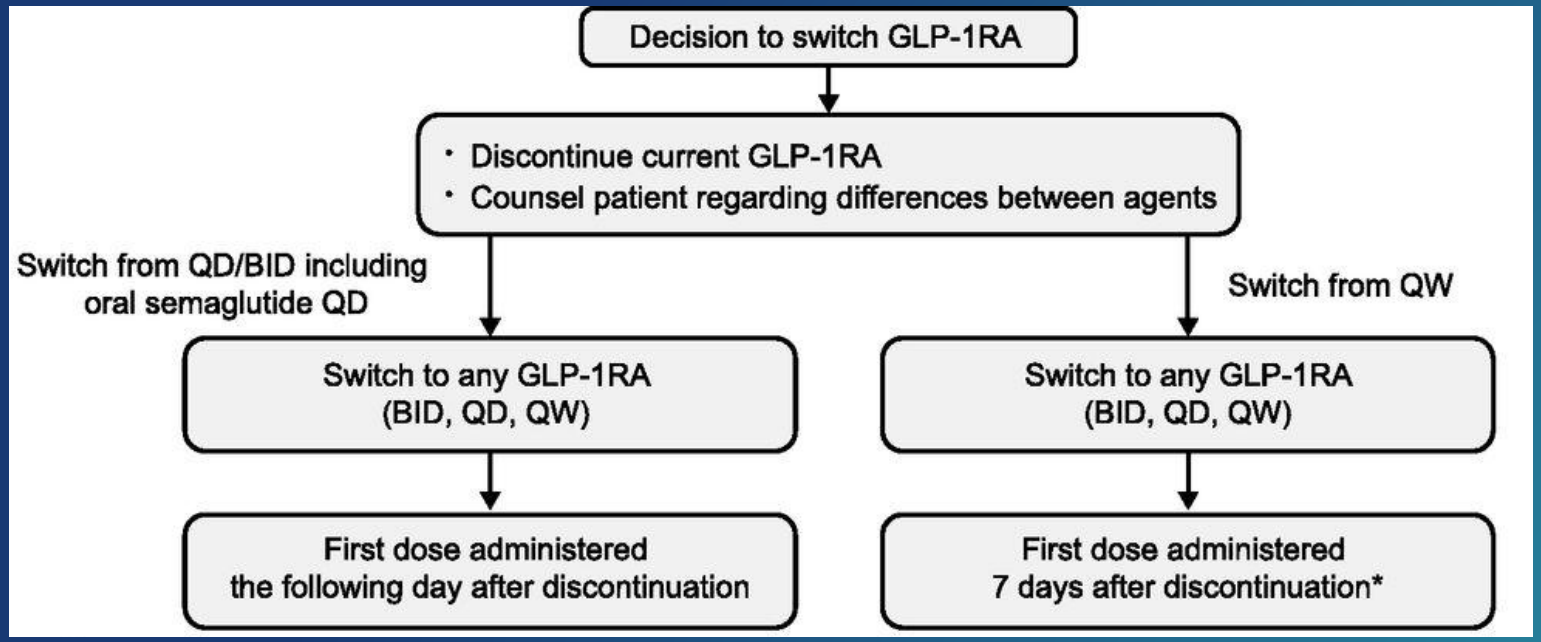
✔ Similar safety and precautions to GLP-1RA prescribed for Type 2 Diabetes
✔ Can titrate dose slower depending on adverse effects and efficacy

GLP-1-RA Prescribing Considerations

- Consider Liraglutide 3.0 mg or Semaglutide 2.4 mg if insufficient weight loss with Liraglutide 1.8 mg or Semaglutide 1.0 mg
- Semaglutide 2.0 FDA approved for diabetes available soon.
- Supply chain issues with Semaglutide 2.4 mg, use Liraglutide 3.0 mg for new start if needed.

Frias 2021; Jain 2021

Switching between GLP-1-RAs



Agent	Frequency	Equivalent Dose†			
Exenatide	QW			2 mg	
Dulaglutide	QW		0.75 mg	1.5 mg	
Semaglutide	QW		0.25 mg	0.5 mg	1 mg
Liraglutide	QD	0.6 mg	1.2 mg	1.8 mg	
Lixisenatide	QD	10 µg	20 µg		
Oral semaglutide	QD	3 mg	7 mg	14 mg	
Exenatide	BID	5 µg	10 µg		

Jaime 2020

Case 1: L.J.

- Nutrition: Appropriate portions, plate-planning
- Activity: Short brisk walks BID, resistance QW
- Behavior: SMART goal for activity
- Meds: Stopped glipizide, metoprolol
- Meds: Started semaglutide, titrate to 2.4 mg

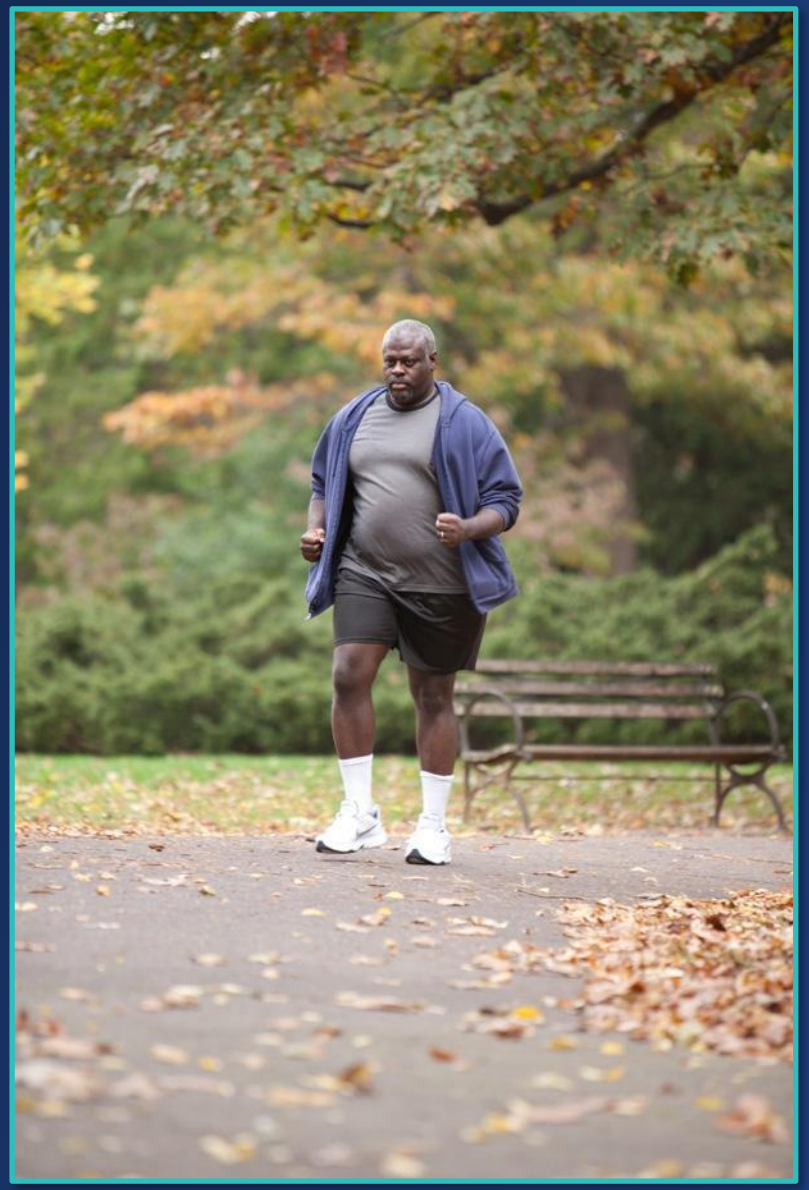
- "Less hungry," better satiety, smaller portions
- Lost 15% body weight, experienced comorbidity improvement in T2D, HTN, asthma

Case 2: M.D.

67-year-old male with T2D, A1C 6.8, BMI 45

- Retinopathy, neuropathy, CKD3
- PMH: HTN, HL, chronic low back pain, DPN
- Labs: A1C 10.0, Creat 1.7, GFR 47
- Recommended to lose weight to treat low back pain by orthopedic surgery consultant.

"I quit alcohol and I'm working hard on cigarettes. Now it's sweets. I opened a sleeve of Oreos the other day and ate the whole thing."



M.D.'s Medications

- Empagliflozin 25 mg po QD
- Metformin XR 1000 mg po BID
- Valsartan-HCTZ 320-25 mg po QD
- Rosuvastatin 5mg po QD
- Paroxetine 30 mg po QD
- Gabapentin 300 mg po TID

Which medications are obesogenic?

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- Valsartan-HCTZ 320-25 mg po QD
- Rosuvastatin 5mg po QD
- Paroxetine 30 mg po QD
- Gabapentin 300 mg po TID

- Paroxetine
- Gabapentin ~ 2.2 kg

Fava 2000

Which AOM would you choose for M.D.?

"Hungry Brain"
Phentermine-
Topiramate

"Emotional Brain"
Bupropion-
Naltrexone

"Hungry Gut"
GLP-1-RA
Liraglutide
Semaglutide

"Slow Burn"
Phentermine

Acosta 2021; icons from Noun project.

Bupropion-Naltrexone (8/90 mg)

MOA: DA/NE reuptake inhibitor + opioid antagonist

Dose: titrate from 1 tab po QAM to 2 tabs PO BID by 1 tab per week, max dose 1 tab BID with CYP2B6 inhibitors (eg clopidogrel)

CI's: Uncontrolled HTN; seizure, bulimia or anorexia nervosa; abrupt DC of alcohol, BDZP, barbiturate, antiepileptic; chronic opioid use; MAOI use within 14 days; pregnancy.

AE's: black box - suicidal thoughts / neuropsychiatric reaction; nausea, headache, insomnia, dizziness

Counsel: avoid opioid use. Monitor BP and pulse.

Source: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/200063s000lbl.pdf

Bupropion / Naltrexone (Contrave)

Week	Dosing
1	One tab PO QAM
2	One tab PO BID
3	Two tab PO QAM, one tab PO QPM
4	Two tabs PO BID

- Do not take with high fat meals to avoid increasing systemic levels of bupropion and naltrexone.
- Caution with acute hepatitis / liver failure. Reduce dose to one tablet BID with CYP2B6 inhibitors (ticlopidine, clopidogrel)

Source: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/200063s000lbl.pdf

Bupropion-Naltrexone (8/90 mg)

Relative Contraindications: mood changes (bupropion)

- Risk of worsening depression, anxiety, suicidal ideation, mania activation, monitor symptoms

BP and heart rate elevation

- Monitor pulse and BP. Caution with controlled HTN and ASCVD.

Hepatotoxicity (naltrexone)

- Monitor symptoms of hepatitis, DC if elevated LFT or acute liver disease.

Hypoglycemia

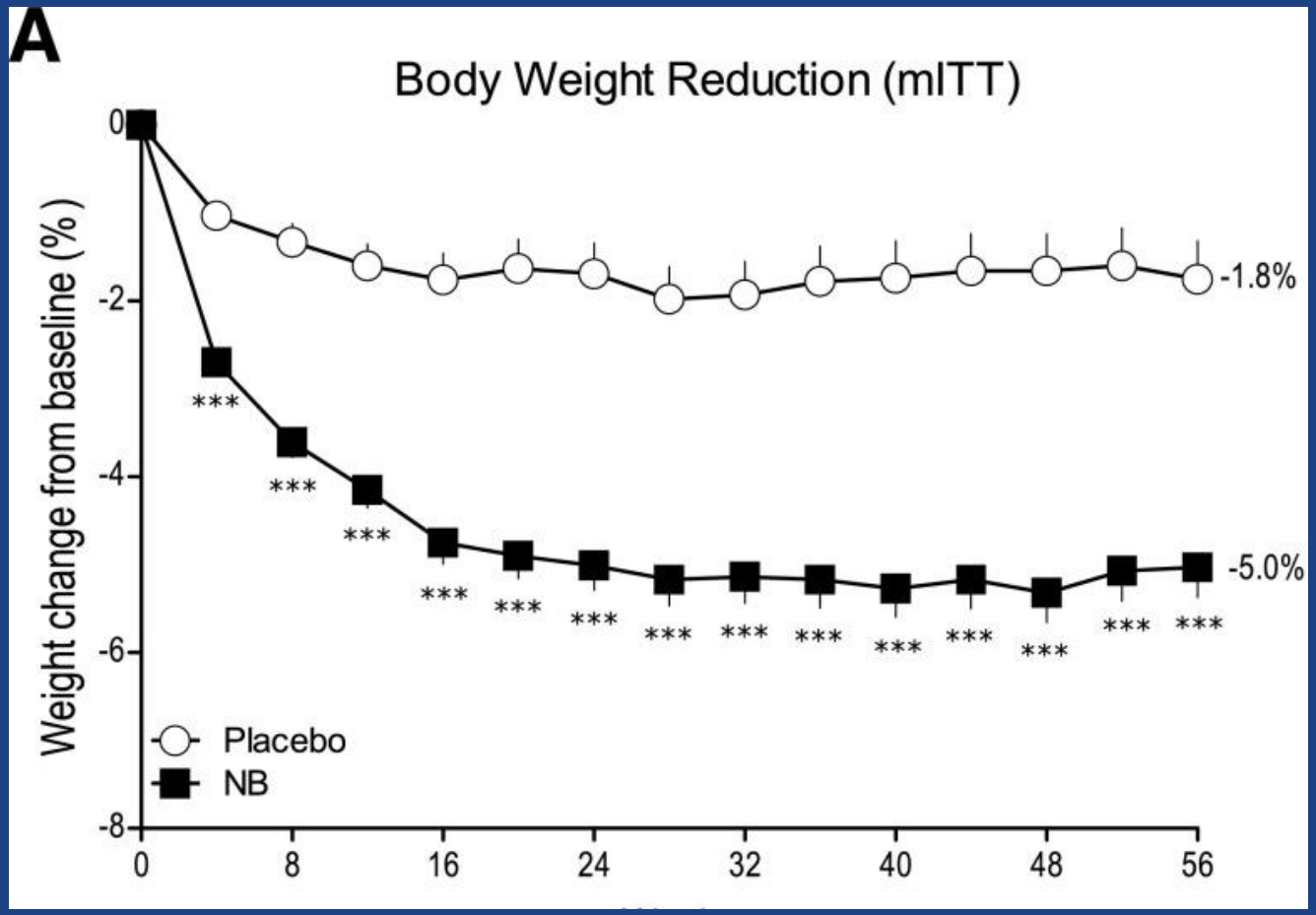
- Monitor and adjust insulin & secretogogues

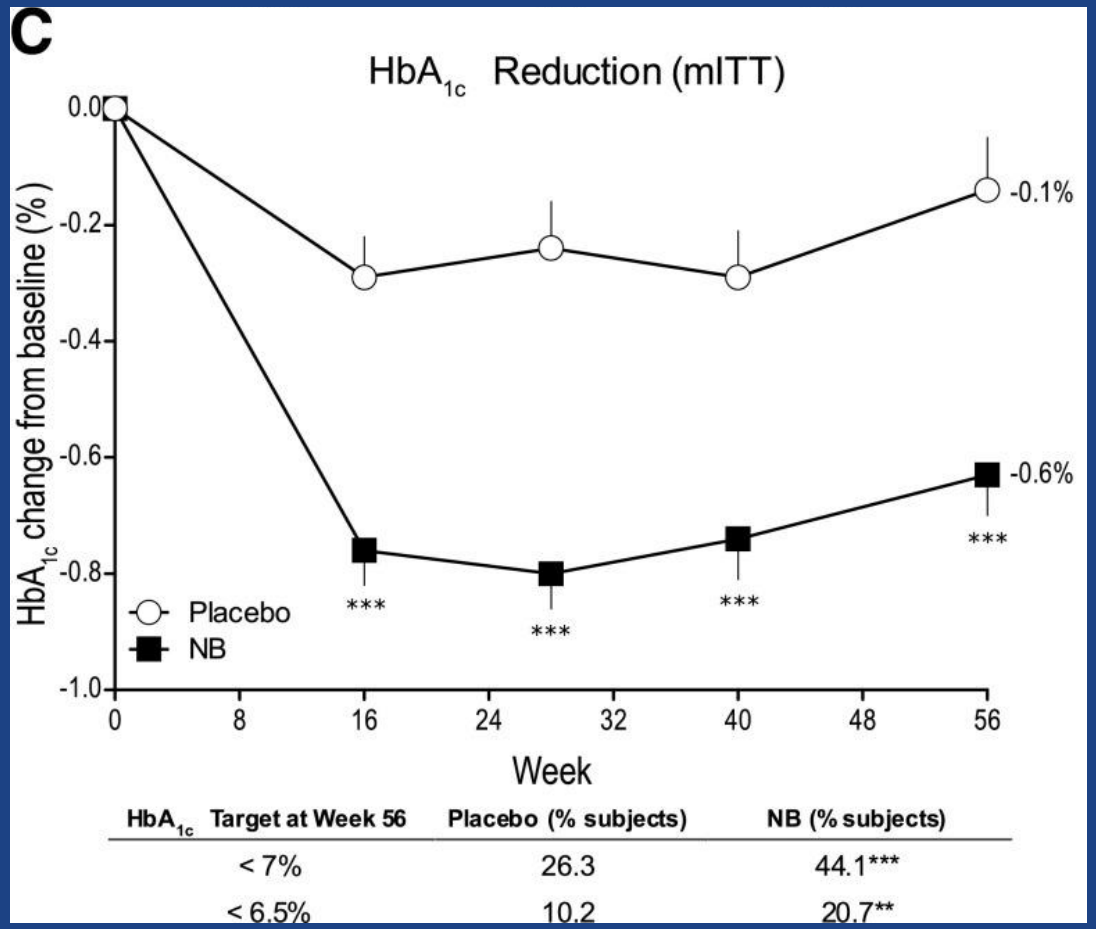
Angle closure glaucoma

- Monitor symptoms.

Source: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/200063s000lbl.pdf

Treat Obesity to Reduce A1C





HbA_{1c} Target at Week 56	Placebo (% subjects)	NB (% subjects)
< 7%	26.3	44.1***
< 6.5%	10.2	20.7**

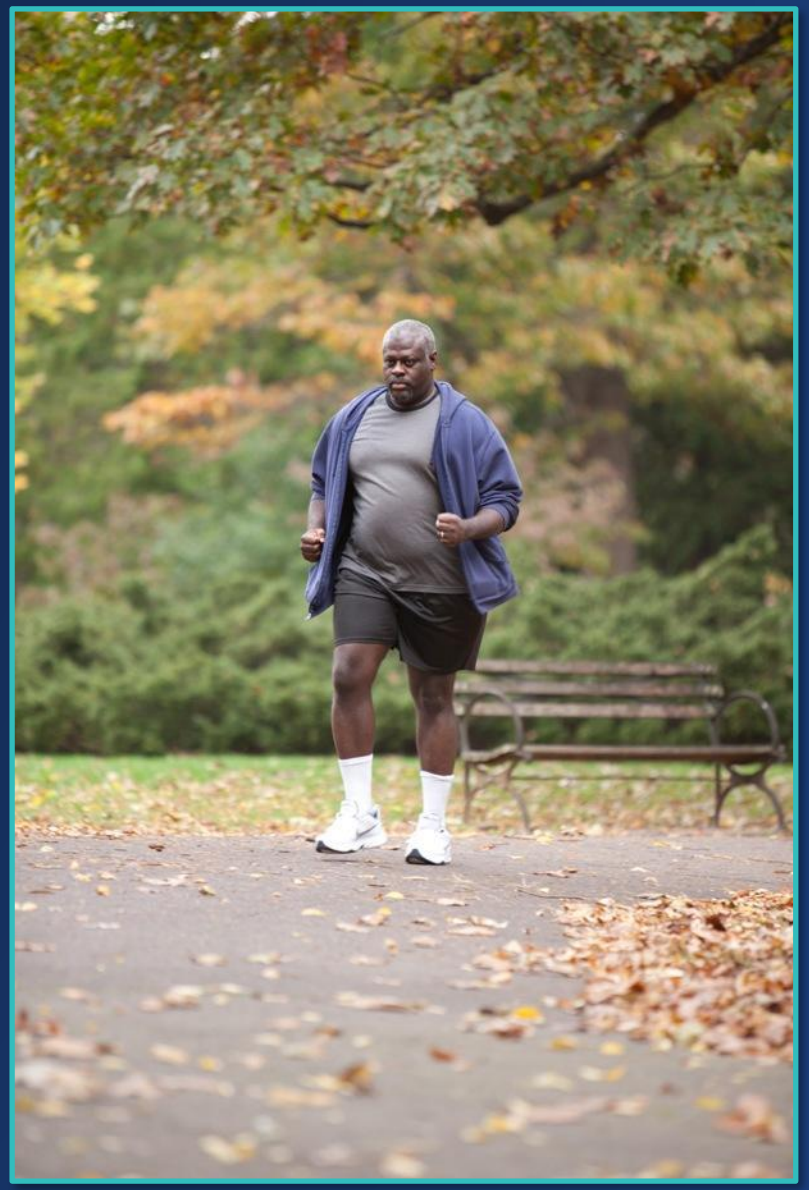
Hollander 2013: Effects of naltrexone SR / bupropion SR on body weight and glycemic parameters (T2D + overweight / obesity

Case 2: M.D.

Nutrition: choose lower carb snacks with protein
Activity: local fitness center "MyFitRx"
Behavior: CBT worksheet for emotional eating, scheduled future appt with therapist
Meds: tapered paroxetine, gabapentin
Meds: started bupropion-naltrexon, titrated dose

"I'm in control of what I'm eating."

Lost 10% body weight, cancelled back procedure, stopped smoking, DPN stable

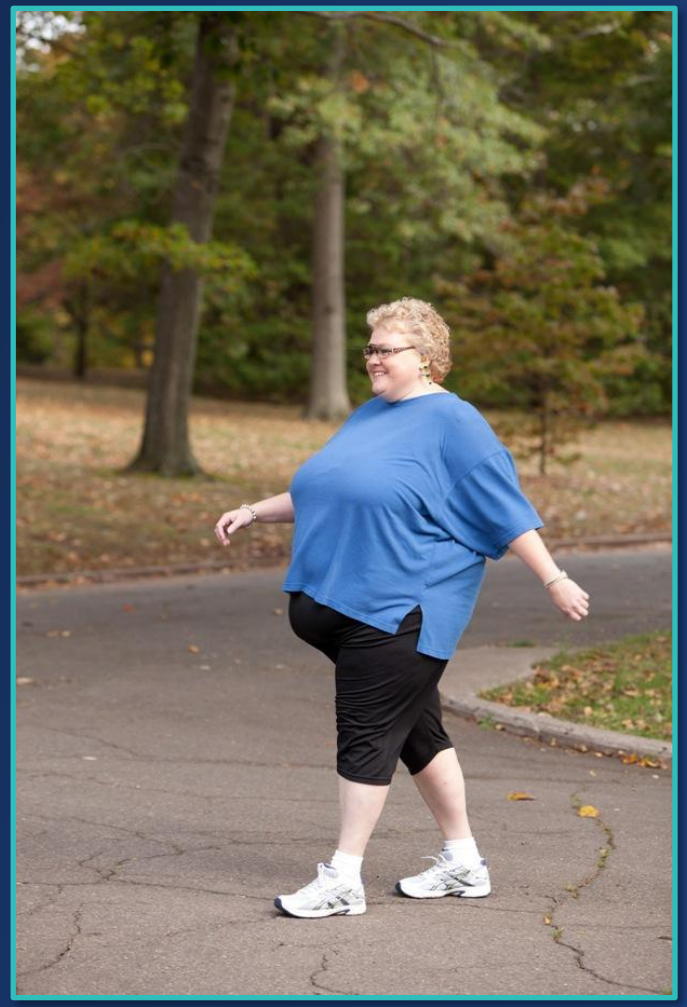


Case 3: C.M.

52-year-old F with preDM, A1C 6.1, BMI 42

- PMH: anxiety, depression, insomnia, chronic GERD, IBS, NAFLD, nephrolithiasis

"I'm miserable all the time. I can only eat bland carbs or I get bloated and I don't have any energy to exercise. I get home from work and I just sit around."



C.M.'s Medications

- Escitalopram 10 mg po QD
- Omeprazole 20 mg po QAM
- Hydroxyzine 100 mg po QHS

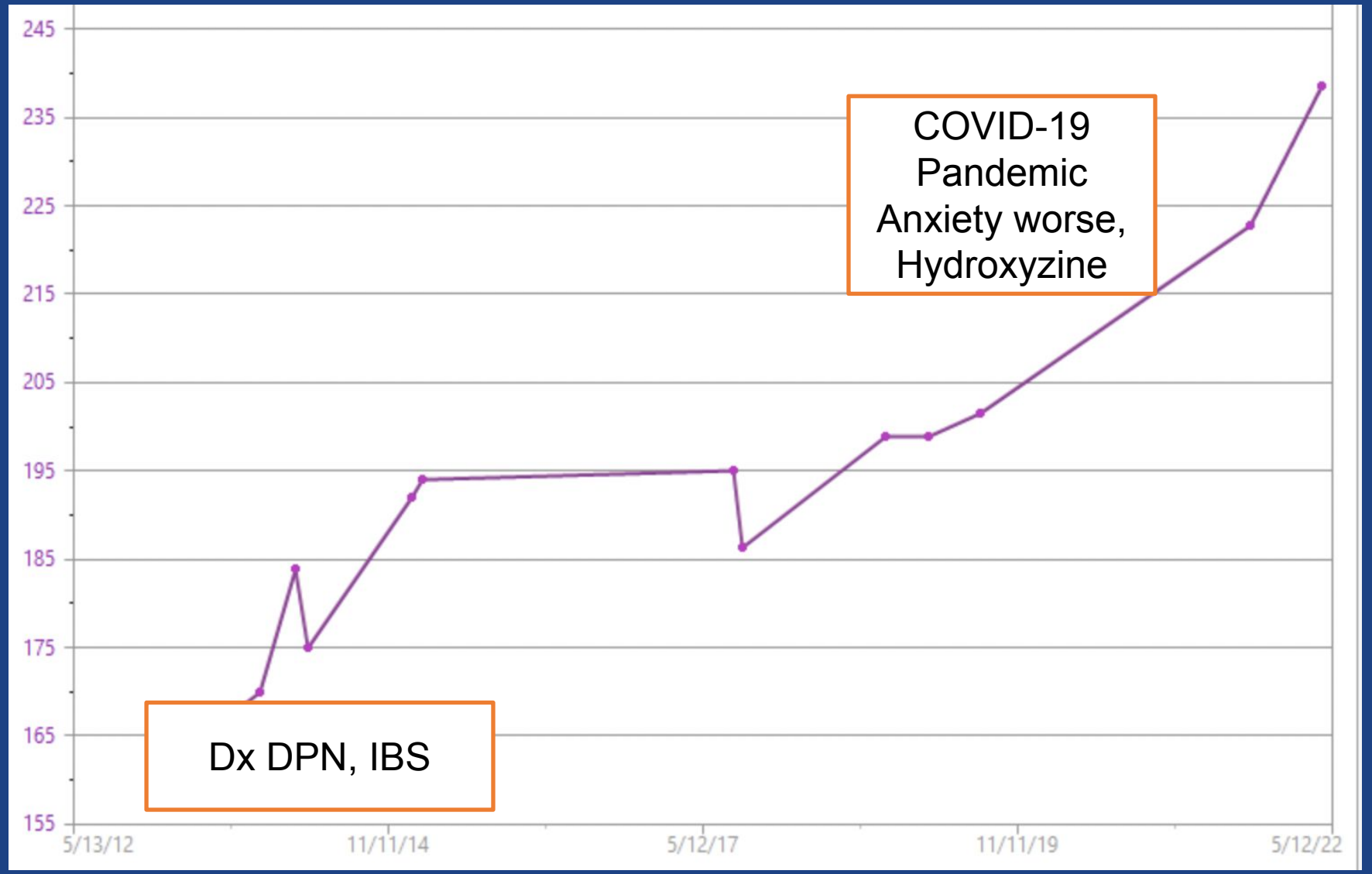
Allergy/intolerance

- Semaglutide SQ – abdominal pain
- Metformin – severe diarrhea

- Hydroxyzine

Jørgensen 2007

C.M.'s Weight History



Which AOM would you choose for C.M.?

"Hungry Brain"
Phentermine-
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"Emotional Brain"
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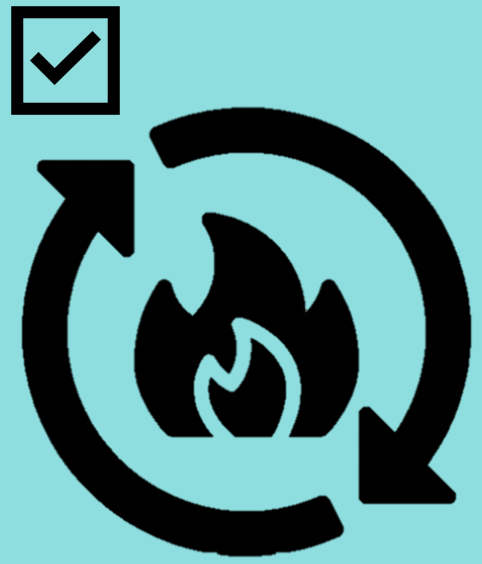
Naltrexone

"Hungry Gut"
GLP-1-RA
Liraglutide
Semaglutide



"Slow Burn"
Phentermine

Acosta 2021; icons from Noun project.

Phentermine-Topiramate CR

MOA: sympathomimetic + anticonvulsant (GABA receptor modulation, carbonic anhydrase inhibition, glutamate antagonism)

Dose: start at 3.75/23 mg QD, maximum 15/92 mg QD, if CrCl<50 mL/min max 7.54/46; if Child-Pugh 7-9, max 7.5-46

CI's: pregnancy or lactation, glaucoma, uncontrolled hyperthyroidism, recent MAOI use within 14 days, allergy

RCI's: tachycardia, depressed/suicidal thoughts, sleep disturbance, attention / memory disturbance, metabolic acidosis

Counsel: REMS, AE's – paresthesia, dizziness, dysgeusia, insomnia, constipation, dry mouth

Phentermine / Topiramate CR (Qsymia)

Pill	Dosing
3.75/23 mg	One tab PO QAM X14 days
7.5/46 mg	One tab PO QAM X3 months
	If < 3% weight loss, consider DC or increase dose as follows:
11.25/69 mg	One tab PO QAM X14 days
15/92mg	One tab PO QAM X3 months
	If <5% weight loss, consider DC Taper: one pill every other day X1 week then stop.

Source: https://pro.aace.com/files/obesity/toolkit/qsymia_patient_info.pdf

Topiramate: risk of oral cleft defect

HIGHLY EFFECTIVE
Methods to use alone

IUD
-copper
-levonorgestrel

Implant (levonorgestrel)

Tubal sterilization
Partner vasectomy

ACCEPTABLE
Methods to use together

One of these:
Hormonal contraception
-estrogen/progestin
  -oral
  -transdermal
  -vaginal ring
-progestin only
  -oral
  -injection

And one of these:
Barrier method
-diaphragm + spermicide
-cervical cap + spermicide
-male condom
  +/- spermicide

ACCEPTABLE
Methods to use together

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-cervical cap + spermicide

And one of these:
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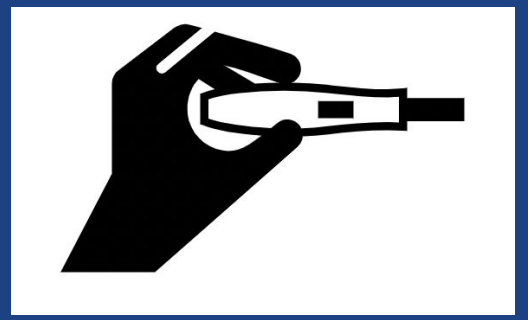


✔ Mfr. recommends pregnancy test prior to use and monthly

Phentermine / Topiramate CR (Qsymia)

- CDC US Medical Eligibility Criteria for Contraception
  - Topiramate is a CYP3A4 inducer and <u>may</u> reduce effectiveness of CHC and POP.

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Obesity	a) Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥ 30 kg/m²	1		1		1		2		1		2	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1		1		2*		1*		3*		3*	
	b) Lamotrigine	1		1		1		1		1		3*	

Key:	
1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Source: CDC US Medical Eligibility Criteria

Phentermine / Topiramate CR (Qsymia)

- Relative Contraindications: Qsymia increases heart rate.
  - Monitor heart rate. Do not use if recent MI or stroke, serious arrhythmia, or congestive heart failure. Caution with controlled ASCVD or HTN.

	Placebo N=1561 n (%)	Qsymia 3.75 mg/23 mg N=240 n (%)	Qsymia 7.5 mg/46 mg N=498 n (%)	Qsymia 15 mg/92 mg N=1580 n (%)
Greater than 5 bpm	1021 (65.4)	168 (70.0)	372 (74.7)	1228 (77.7)
Greater than 10 bpm	657 (42.1)	120 (50.0)	251 (50.4)	887 (56.1)
Greater than 15 bpm	410 (26.3)	79 (32.9)	165 (33.1)	590 (37.3)
Greater than 20 bpm	186 (11.9)	36 (15.0)	67 (13.5)	309 (19.6)

Patients with elevations in heart rate in clinical studies of up to one year.
Source: https://qsymia.com/patient/include/media/pdf/prescribing-information.pdf

Phentermine / Topiramate CR (Qsymia)

Relative Contraindications:

Metabolic acidosis (topiramate):

- Hyperchloremic, non-anion-gap metabolic acidosis and hypokalemia
- Caution if renal & lung disease, diarrhea, status epilepticus, surgery, keto diet
- Caution use with carbonic anhydrase inhibitors (Zonisamide, Acetazolamide)
- Stay hydrated
- Check electrolytes at one month
- Monitor symptoms, nephrolithiasis

Glaucoma

- Topiramate associated with secondary angle closure glaucoma
- Typically in 1st month of treatment
- Monitor for blurry vision and eye pain and stop drug if present.

Source: https://qsymia.com/patient/include/media/pdf/prescribing-information.pdf

Phentermine / Topiramate CR (Qsymia)

Relative Contraindications:

Elevated creatinine

- Decreased GFR peaks at 4-8 weeks, monitor labs

Hypoglycemia

- Monitor and adjust insulin & secretogogues

Hypotension

- Monitor and adjust anti-hypertensive medications

CNS depression

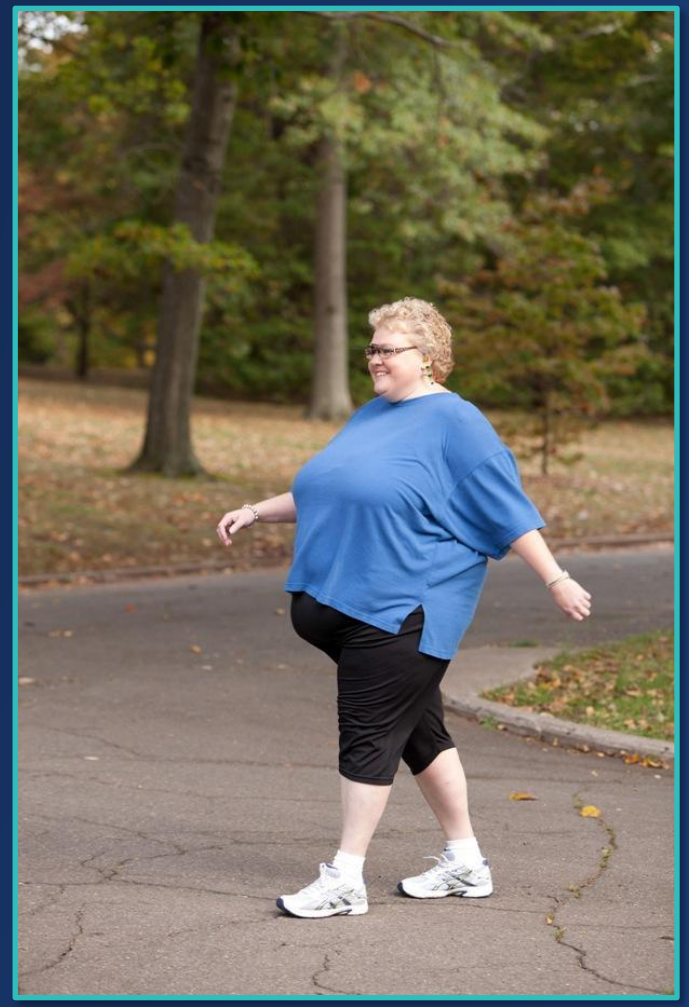
- Avoid alcohol use

Case 3: C.M.

52-year-old F with preDM, A1C 6.1, BMI 42

- PMH: anxiety, depression, insomnia, chronic GERD, IBS, NAFLD, nephrolithiasis

"I had another kidney stone and the emergency room doctor stopped my medication."



Phentermine

MOA: Inhibits Na2+-dependent NE transporter, reduces NE uptake
Inhibits serotonin and dopamine reuptake

Dose: 15-37.5 mg QD *(alt* 18.75 Qd or BID), or 8mg TID

CI's: Active CV disease, uncontrolled HTN, cardiac arrhythmias, hyperthyroidism, glaucoma

AE's: Dry mouth, constipation, insomnia, palpitations, HA, irritability

Counsel: Schedule IV controlled substances, monitor BP. Avoid with EtOH. Heavy machinery warning.

Phentermine Myths and Facts

No evidence of addiction, withdrawal

No established relationship related to cardiac valvulopathy or pulmonary hypertension

No studies on people with cardiovascular disease, but among those studied:

- HR “short-term … group had no significant change in HR at 6, 12, or 24 months”
- HR “medium-term [biggest change was] at 6 months and was 1.6 (95% CI: 1.0-2.2) bpm “
- SBP “stable at 6 and 12 months, but at 24 months, it had increased by 1.8 (0.5-3.2) mmHg”

Do know your state prescribing laws for short term or long-term use.

Lewis 2019

Phentermine: Long Term Outcomes

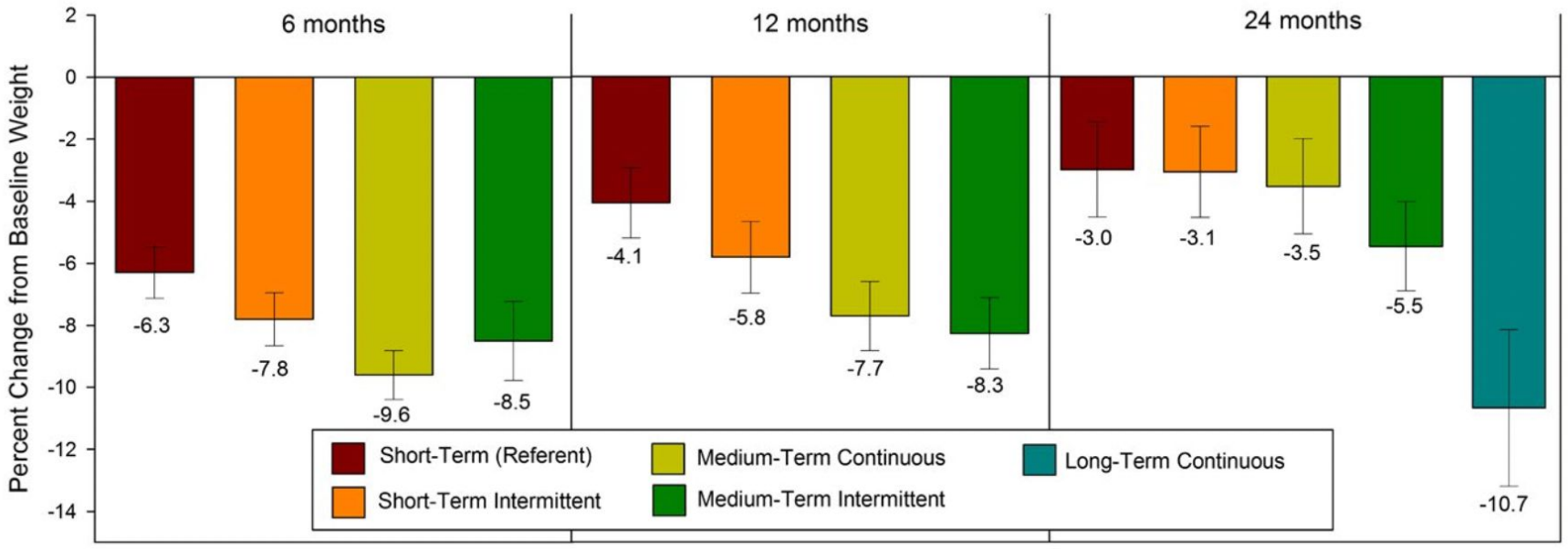


Figure 3 Estimated percent weight loss at 6 months and 1 and 2 years after phentermine initiation among responders; results from multivariable linear models. Models include only phentermine responders, patients who had lost ≥3% body weight by 3 months after initiating medication. Estimates at each time point are from separate multivariable linear models, and *n* (%) by group over follow-up is presented in Table 2. Note that because real clinical follow-up does not occur at exact 6-month intervals, weights were drawn from an acceptable time window of outpatient visits around each time point of interest, as outlined in *Methods*. Estimates for the referent group (on-label continuous) were based on the y-intercept of multivariable models in the case in which all covariates are set to referent. Estimates for comparison groups were generated by summing the intercept weight loss and the additional change in weight by group at each time point. Error bars represent 95% CI for each estimate.

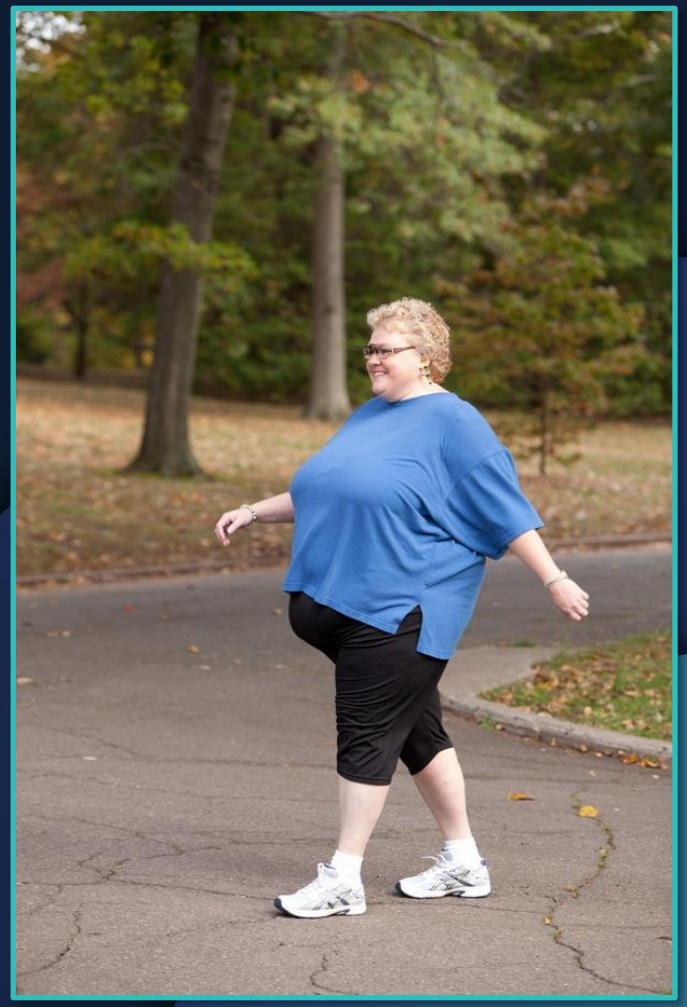
Lewis 2019

Case 3: C.M.

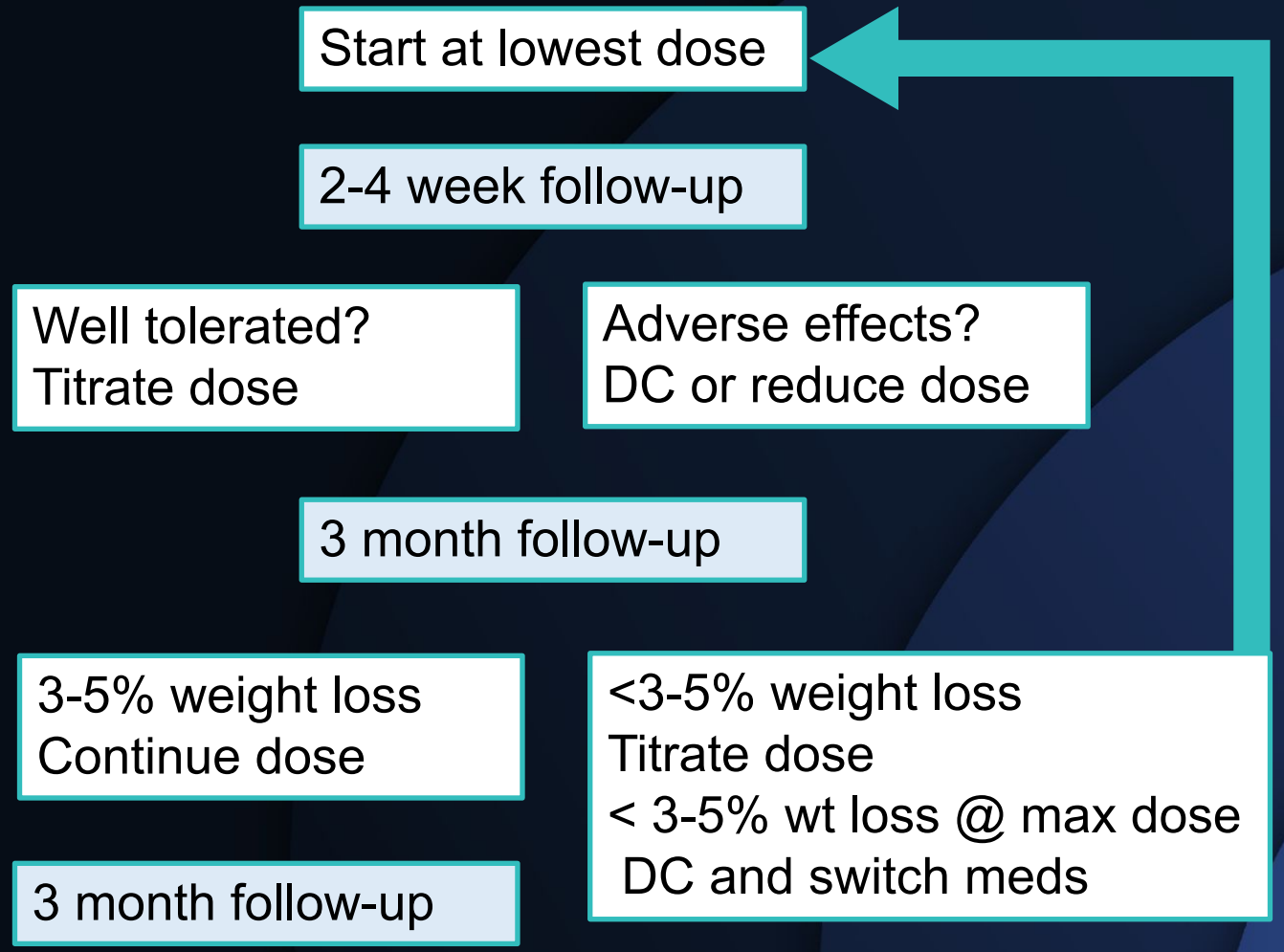
Nutrition: plate planning with protein every meal and non-inflammatory vegetables / complex carbs
referral to GI / IBS specific nutritionist
Activity: add pilates three days a week, brisk walk after work
Behavior: SMART goal sheet for activity
Meds: tapered hydroxyzine
Meds: continued phentermine

" I have a lot more energy, and now that I'm moving I feel better."

Lost 7% body weight, bloating improved.



Initiating Anti-Obesity Medications



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FOR TYPE 2 DIABETES

Weight Loss and Impact on ABCD's

% weight loss	ABCD
5-≥10%	Male hypogonadism, SUI
5-≥15%	T2D, HLD, HTN, PCOS, NAFLD
7-8%	Asthma / reactive airway disease
7-11%	OSA
10%	PreDM, metabolic syndrome, female infertility
≥10%	Osteoarthritis, GERD
10-40%	Steatohepatitis

Barriers to Prescribing AOM's

- Lack of training in medical school and residency
- Lack of knowledge
  - Evidence-based obesity guidelines (AACE/AHA/TOS, Endocrine Society, Obesity Medicine Association)
- Lack of time and competing priorities in office visits
- Overemphasis on general advice / under-emphasis on intensive behavioral / nutrition / pharmacotherapy
- Obesity bias
- Lack of insurance coverage and high copays for medications
- Lack of "obesity specialist" for referral and treatment (eg endocrinologist, multi-disciplinary team)

Michigan Medicaid Formulary

Anorexiant Combinations	Qsymia 3.75mg-23mg, 7.5mg-46mg, 11.25mg-69mg, 15mg-92mg Capsule	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	benzphetamine hcl 50mg tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	diethylpropion 25mg, ER 75mg tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	phendimetrazine 35mg tablet, phendimetrazine ER 105mg capsule	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	phentermine 15mg, 30mg, 37.5mg capsule, phentermine 37.5 tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	Adipex-P 37.5 Mg Capsule, Adipex-P 37.5 Mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred

Anti-Obesity - Fat Absorption Decreasing Agents	XENICAL 120 MG CAPSULE	*PDL-P AGE PA
Anti-Obesity - Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	SAXENDA 18 MG/3 ML PEN	*PDL-P AGE PA
	WEGOVY 0.25 MG/0.5 ML PEN	*PDL-P AGE PA
	WEGOVY 0.5 MG/0.5 ML PEN	*PDL-P AGE PA
	WEGOVY 1 MG/0.5 ML PEN	*PDL-P AGE PA
	WEGOVY 1.7 MG/0.75 ML PEN	*PDL-P AGE PA
	WEGOVY 2.4 MG/0.75 ML PEN	*PDL-P AGE PA
Anti-Obesity - Opioid Antag/Norepinephrine & Dopamine Reuptake Inhibit	CONTRAVE ER 8-90 MG TABLET	*PDL-P AGE PA

Prior Authorization Criteria

Medicaid Health Plan Pharmacy Benefit

This webpage is designed to provide easy access for members and providers looking for information on the drugs and supplies covered by Michigan Medicaid Health Plans.

All plans must at a minimum cover the drugs listed on the Medicaid Health Plan Common Formulary.

History of Formulary Changes:

- Pre-Single PDL Changes (before October 1, 2020)
- Post-Single PDL Changes (after October 1, 2020)

General Formulary Information

FOR PROVIDERS AND PRESCRIBERS ONLY

Prior Authorization (PA)	Step Therapy
The Prior Authorization criteria for drugs indicated on the Medicaid Health Plan Common Formulary as requiring PA is below: Drug PA Criteria A standard prior authorization form, FIS 2288, was created by the Michigan Department of Insurance and Financial Services (DIFS) to simplify the process of requesting prior authorization for prescription drugs. This form or a prior authorization used by a health plan may be used.	The Step Therapy criteria for drugs indicated on the Medicaid Health Plan Common Formulary as requiring ST is below: Step Therapy Criteria

https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-380454--,00.html

Prior Authorization Criteria

MHP Common Formulary Prior Authorization Criteria

ANTIOBESITY AGENTS

Drug Class: Anti-Obesity Agents

Preferred Agents: *Clinical Prior Authorization below*

Pancreatic Lipase Inhibitors:
Xenical (orlistat)

GLP-1 Agonists:
Saxenda (liraglutide)
Wegovy (semaglutide)

Combination Products:
Qsymia (phentermine/topiramate); C-IV
Contrave (bupropion/naltrexone)

Noradrenergic Sympathomimetic Agents:
benzphetamine (only available as generic); C-III
diethylpropion (only available as generic); C-IV
Adipex-P (phentermine); C-IV
Lomaira (phentermine); C-IV
phentermine; C-IV
phendimetrazine (only available as generic); C-III

Clinical Prior Authorization

Initial

- Patient must have a body mass index [BMI] ≥ than 30 kg/m^2; **OR**
- Patient must have a body mass index [BMI] ≥ than 27 kg/m^2 but <30 kg/m^2 and at least one of the following risk factors:
  - hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea; **AND**
- Patient age ≥12 years (Xenical, Saxenda); **OR**
- Patient age ≥18 years (Wegovy, Qsymia, Contrave, benzphetamine, diethylpropion, phentermine, phendimetrazine); **AND**
- Prescriber attests to patient's absence of any contraindications to use of the requested product; **AND**
- Prescriber attests that the patient is not pregnant or lactating; **AND**
- Prescriber attests that at least one previously documented weight reduction attempt in the past year; **AND**
- Prescriber attests medication therapy is part of a total treatment plan including a calorie and fat restricted diet and exercise regimen.

MHP Common Formulary Prior Authorization Criteria

MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.

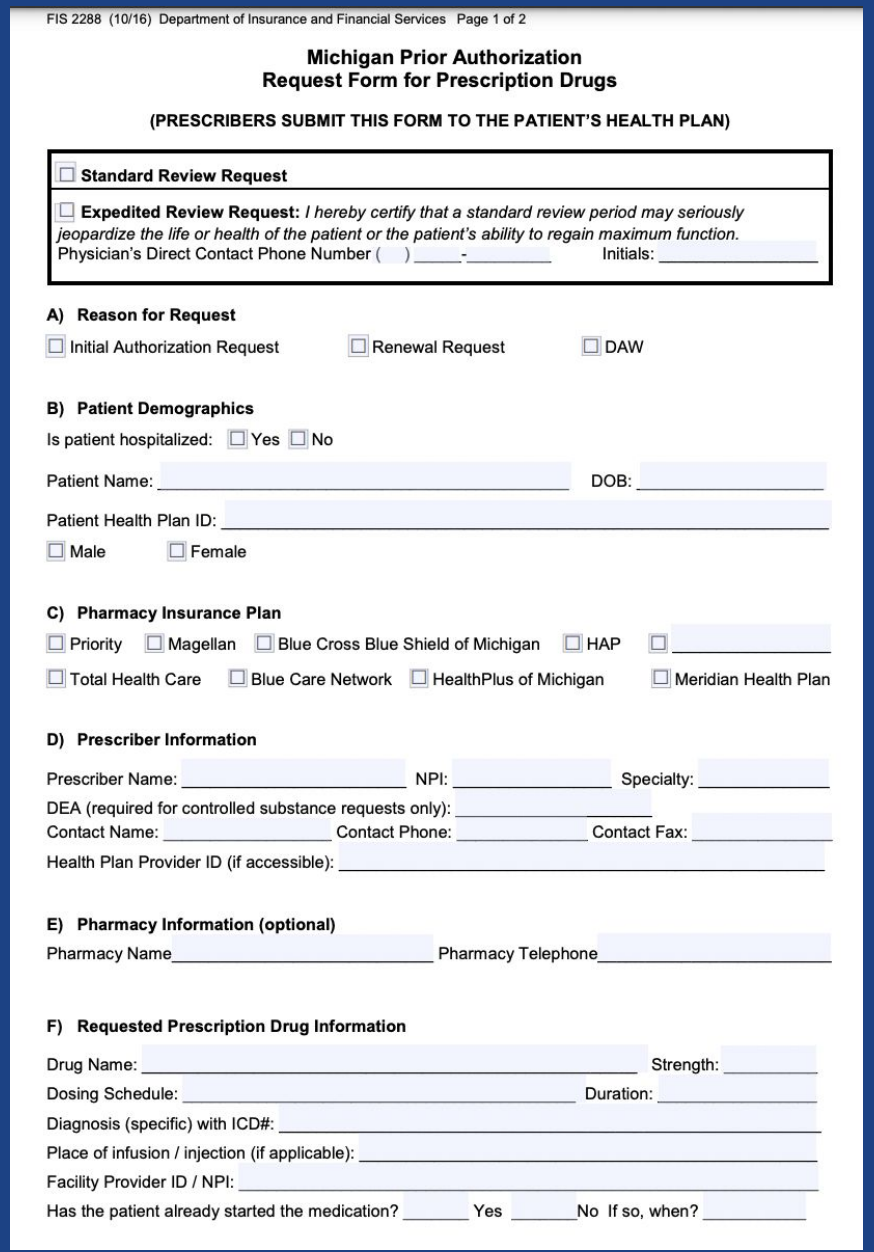
Renewal

- Prescriber attests that patient has achieved a weight loss of ≥ 5% of weight at time of last prior authorization.
- Length of approval for both initial and renewal: 6 months

❒ **Duration of Approval**: 6 months

https://www.michigan.gov/documents/mdhhs/MCO_Common_Formulary_PA_Criteria_FINAL_522828_7.pdf

Standard Prior Authorization Form



FIS 2288 (10/16) Department of Insurance and Financial Services Page 1 of 2

Michigan Prior Authorization Request Form for Prescription Drugs

(PRESCRIBERS SUBMIT THIS FORM TO THE PATIENT'S HEALTH PLAN)

☐ **Standard Review Request**

☐ **Expedited Review Request:** *I hereby certify that a standard review period may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*
Physician's Direct Contact Phone Number ( ) _____-_____ Initials: _____

A) Reason for Request

☐ Initial Authorization Request ☐ Renewal Request ☐ DAW

B) Patient Demographics

Is patient hospitalized: ☐ Yes ☐ No

Patient Name: _____ DOB: _____

Patient Health Plan ID: _____

☐ Male ☐ Female

C) Pharmacy Insurance Plan

☐ Priority ☐ Magellan ☐ Blue Cross Blue Shield of Michigan ☐ HAP ☐ _____

☐ Total Health Care ☐ Blue Care Network ☐ HealthPlus of Michigan ☐ Meridian Health Plan

D) Prescriber Information

Prescriber Name: _____ NPI: _____ Specialty: _____

DEA (required for controlled substance requests only): _____

Contact Name: _____ Contact Phone: _____ Contact Fax: _____

Health Plan Provider ID (if accessible): _____

E) Pharmacy Information (optional)

Pharmacy Name_____ Pharmacy Telephone_____

F) Requested Prescription Drug Information

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Duration: _____

Diagnosis (specific) with ICD#: _____

Place of infusion / injection (if applicable): _____

Facility Provider ID / NPI: _____

Has the patient already started the medication? _____ Yes _____No If so, when? _____

FIS 2288 (10/16) Department of Insurance and Financial Services Page 2 of 2

G) Rationale for Prior Authorization (e.g., information such as history of present illness, past medical history, current medications, etc.; you may also attach chart notes to support your request if you believe they will assist with the review process)

_____

_____

_____

_____

H) Failed/Contraindicated Therapies

Drug Name	Strength	Dosing Schedule	Duration	Adverse Event/Specific Failure

I) Other Pertinent Information (Optional - to be filled out if other information is necessary such as relevant diagnostic labs, measures of response to treatment, etc.) Please refer to plan's website for additional information that may be necessary for review. Please note that sending this form with insufficient clinical information may result in extended review period or adverse determination.

_____

_____

_____

I represent to the best of my knowledge and belief that the information provided is true, complete and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Physician's Name: _____

Physician's Signature: _____

Date: _____

PA 218 of 1956 as amended requires the use of a standard prior authorization form by prescribers when a patient's health plan requires prior authorization for prescription drug benefits.

For Health Plan Use Only

Request Date: _____ LOB: _____
Approved: _____ Denied: _____
Approved By: _____ Denied By: _____
Effective Date: _____ Reason for Denial: _____
Additional Comments: _____

DIFS Michigan Department of Insurance and Financial Services
DIFS is an equal opportunity employer/program.
Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.
Visit DIFS online at: www.michigan.gov/difs Phone DIFS toll-free at: 877-999-6442

https://www.michigan.gov/documents/difs/FIS_2288_501398_7.pdf

Why did my prior authorization get rejected?

- ✔ Does the patient have a BMI of ≥27 and at least one approved co-comorbidity if BMI <30? (HTN, CAD, DM, HLD, OSA)
- ✔ Did I attest that the patient had tried a prior weight loss attempt?
- ✔ Did I provide documentation of a calorie and fat restricted diet and planned exercise regimen?

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Why did my prior authorization get rejected?

Authorization note template:

I evaluated @name@, a @age@ year old adult for an anti obesity medication.

@vs@

(BMI≥30) Starting weight was *** and starting BMI was ***

(BMI 27-29.9) Starting weight was *** and starting BMI was *** with the following comorbidity: *** hypertension, CAD, diabetes, hyperlipidemia, sleep apnea

I attest that:

- ✔ there are no contraindications to the medication I have prescribed.
- ✔ the patient is not pregnant or lactating.
- ✔ the patient has at least one previously documented weight reduction attempt in the last year. Details include ***.
- ✔ the patient is engaging in a calorie and fat restricted diet and exercise regimen. Details include: ***

I recommended that the patient engage in the Diabetes Prevention Program and/or Diabetes Education Program.

What about repeat prior authorizations?

- Provide initial attestation information and also:
  - I evaluated @name@ who was prescribed the medication *** on **/**/**. After six months @name@ has experienced a weight change of *** lb, for a percent weight change of **%.

Considerations

If there is a long delay to meet with a nutritionist or other health professional to prescribe a calorie-restricted eating plan, you may want to wait to prescribe AOM until that visit so that your patient maximizes their likelihood of 5% weight loss during Medicaid's 6 month initial authorization period.

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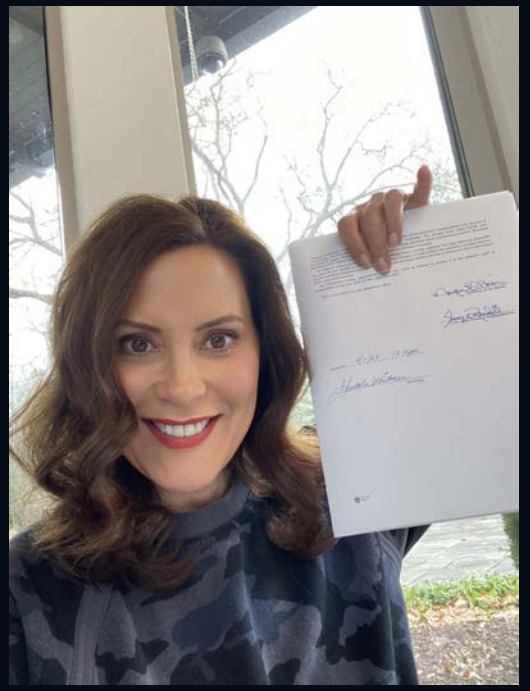
FOR TYPE 2 DIABETES

SB 247: Prior Authorization



https://www.msms.org/

All insurers must have

- Standard electronic PA request process
- Base PA requirements on peer reviewed clinical review criteria
- Requires a licensed physician to review appeal prior to affirming an appeal denial

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FOR TYPE 2 DIABETES

SB 247: Prior Authorization

By June 1 2023

- Must act on urgent PA within 72 hours
- Must act on standard PA within 9 calendar days

Must adopt a performance-based PA program

https://www.ama-assn.org/practice-management/sustainability/new-physician-gold-card-law-will-cut-prior-authorization-delays

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Quality Improvement To-Do List

1. Aim: to increase the utilization of anti-obesity medications for people with obesity on Medicaid who are eligible and would benefit from them.

2. PDSA:
   - Plan: meet with your staff person who assists with prior authorization, review criteria and develop workflow.
   - Do: try prescribing for one patient.
   - See: where there any barriers to authorization?
   - Act: address barriers and continue prescribing when appropriate.

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T2D remission with VLCD eating plan

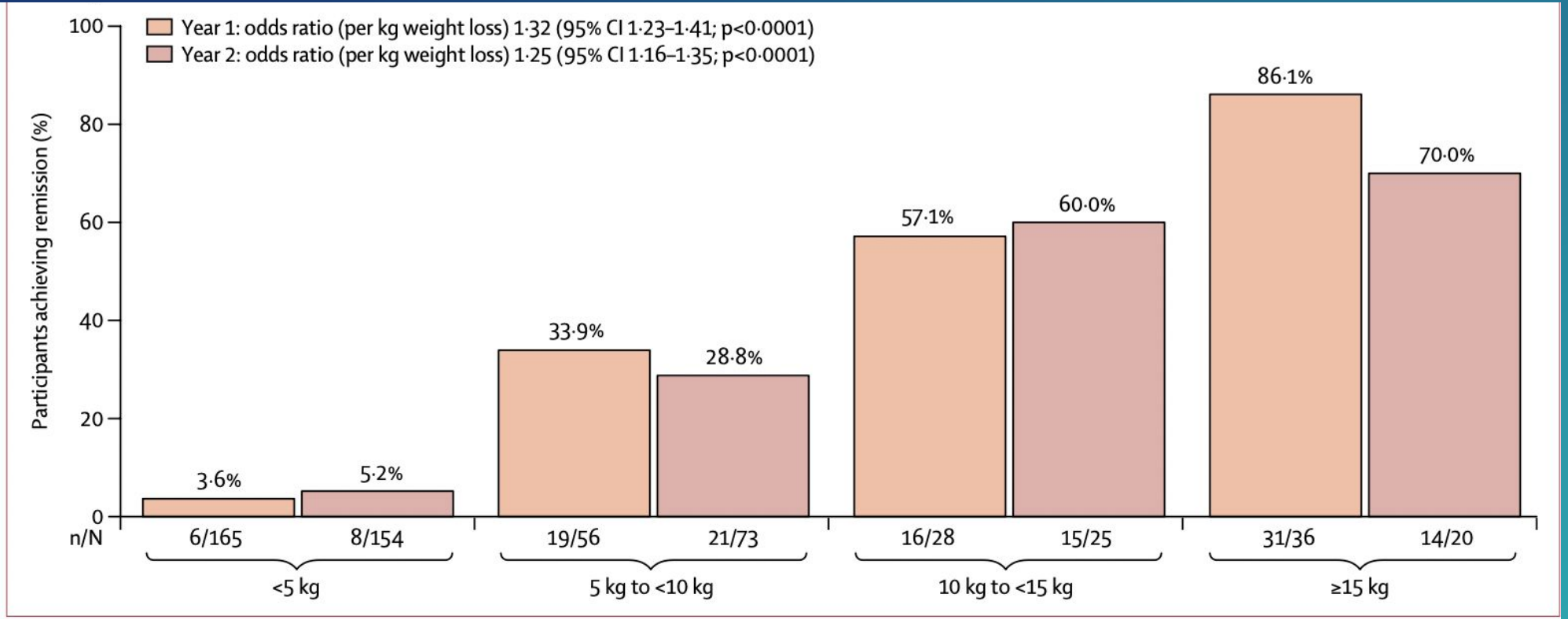

Figure 2: **Primary outcomes and remission of type 2 diabetes in relation to weight loss at 12 and at 24 months**
Regression models adjusted for practice list size, study centre, and a random effect for practice. (A) First coprimary outcome, achievement of at least 15 kg weight loss, by randomised group. (B) Second coprimary outcome, remission of type 2 diabetes (HbA_{1c} <48 mmol/mol [6·5%] and off antidiabetes drugs since baseline), by randomised group. (C) Remission of type 2 diabetes in relation to weight loss achieved (both randomised groups combined).

Lean 2019

ADA Standards on Obesity

- Short term VCLD may be used with medical supervision
- AOM's are effective as adjunct to lifestyle change.
- Reducing overall carbohydrates is beneficial for glycemia. Emphasize high fiber, minimally processed vegetables, fruits and whole grains.

ADA Standards 2022

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DIABETICMedicine

DOI: 10.1111/dme.14122

Research: Epidemiology

Behaviour change, weight loss and remission of Type 2 diabetes: a community-based prospective cohort study

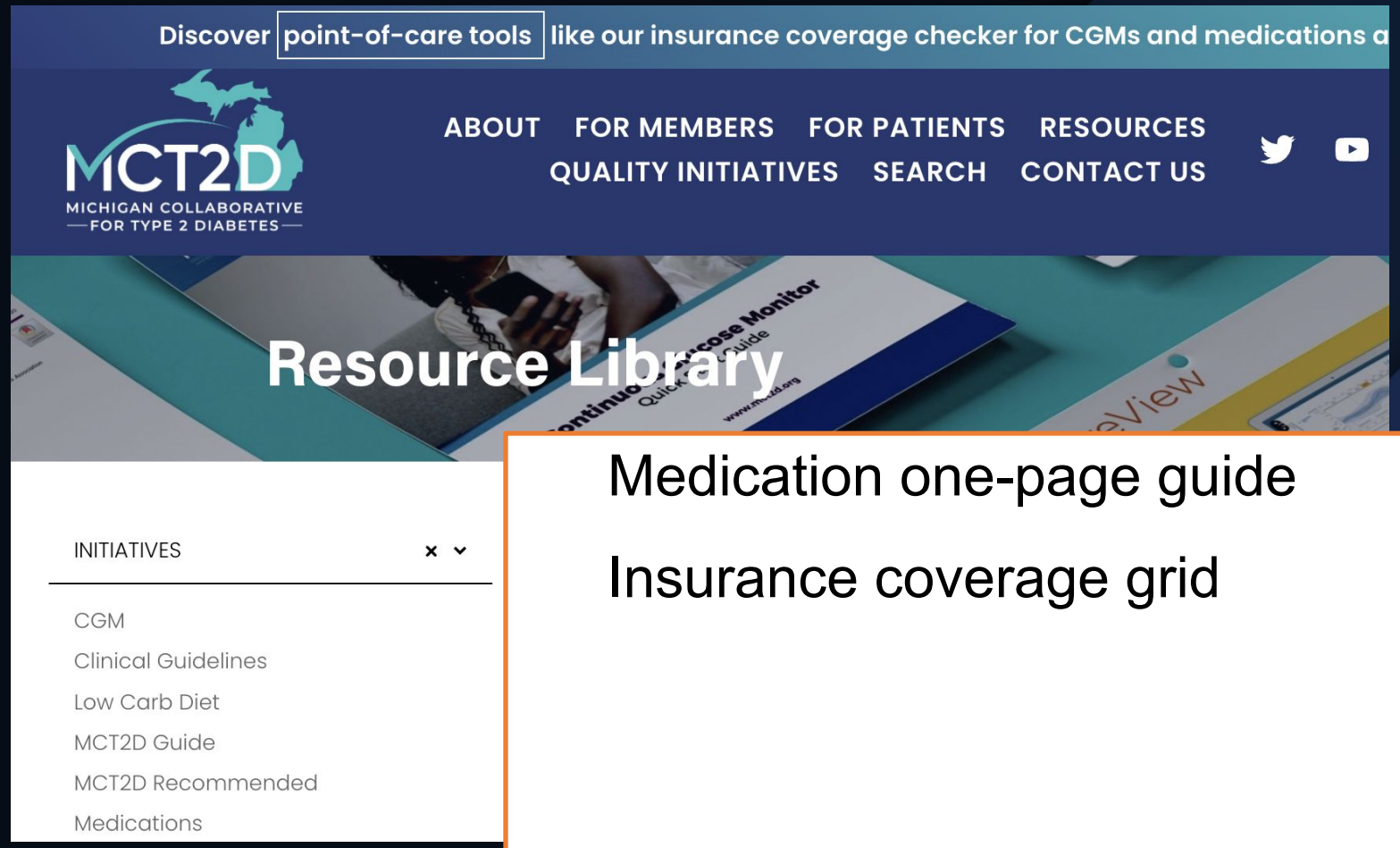
H. Dambha-Miller[1,2,3], A

[1]Primary Care Unit, Department of Public Heal
[2]MRC Epidemiology Unit, University of Cambri
Sciences, University of Southampton, Southam

Accepted 28 August 2019

Weight loss of ≥10% **early in the [Type 2 diabetes] disease** trajectory was associated with a **doubling of the likelihood of remission at 5 years**. This was achieved without intensive lifestyle interventions or extreme calorie restrictions. **Greater attention should be paid to enabling people to achieve weight loss following diagnosis of Type 2 diabetes.**

Resources: Coming Soon



Medication one-page guide

Insurance coverage grid

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FOR TYPE 2 DIABETES

Medication Coverage By Payer in Michigan | Anti-Obesity Medications

MCT2D MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

	PRIVATE PLANS			PUBLIC PLANS	
	BCBSM/BCN	HAP	PRIORITY	MEDICARE	MEDICAID
Phentermine ***High Dose*** *Oral - Daily/With Meals*	Preferred	Preferred - Generic	Preferred. Employers plan rider determines weight loss coverage.	Preferred - Generic Estimated cost: $320/year	Covered on formulary with prior auth and age edit
Phentermine 8 ***Low Dose*** Lomaira *Oral - Daily/With Meals*	Preferred	Preferred - Generic	Preferred. Employers plan rider determines weight loss coverage.	Preferred - Generic Estimated cost: $320/year	Covered on formulary with prior auth and age edit
Phentermine - Topiramate Qsymia *Oral - Daily*	Prior Auth and Quantity Limits Not preferred	✗	Step Therapy: Must try generic weight loss med first. Tier 3. Employers plan rider determines weight loss coverage.	Covered Estimated cost: $1516/year	Covered on formulary with prior auth and age edit
Naltrexone HCl - Bupropion HC Contrave *Oral - 2x Daily*	Prior Auth and Quantity Limits Not preferred	✗	Step Therapy: Must try generic weight loss med first. Tier 3. Employers plan rider determines weight loss coverage.	Covered Estimated cost: $2,260/year	Covered on formulary with prior auth and age edit
Liraglutide Saxenda - 3mg *Injectable - Daily*	Prior Auth and Quantity Limits Not preferred	✗	✗	Covered Estimated cost: $11,108/year	Covered on formulary with prior auth and age edit
Semaglutide Wegovy - 2.4mg *Injectable - Weekly*	Prior Auth and Quantity Limits Not preferred	✗	✗	✗	Covered on formulary with prior auth and age edit

Estimated cost generated- from medicare.gov tool, with Medicare Part D, Washtenaw County selected

Based on Q1-2022 Payer Policies. Subject to Change
See an error? Let us know at ccteam@mct2d.org
Last Updated: 2022-April 28

MCT2D.ORG

Download this coverage table: https://michmed.org/Mx2M3

MCT2D MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Medication Coverage By Payer in Michigan

Medicare Advantage Plan Coverage
Anti-Obesity Medications

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	aetna AETNA	BCBSM/BCN	hap HAP	Humana HUMANA	PriorityHealth PRIORITY	United Healthcare UNITED	wellcare WELLCARE
Phentermine ***High Dose*** *Oral - Daily/With Meals*	X	X	X	X	X	X	X
Phentermine 8 ***Low Dose*** Lomaira *Oral - Daily/With Meals*	X	X	X	X	X	X	X
Phentermine - Topiramate Qsymia *Oral - Daily*	X	X	X	X	X	X	X
Naltrexone HCl - Bupropion HC Contrave *Oral - 2x Daily*	X	X	X	X	X	X	X
Liraglutide Saxenda - 3mg *Injectable - Daily*	X	X	X	X	X	X	X
Semaglutide Wegovy - 2.4mg *Injectable - Weekly*	X	X	X	X	X	X	X

Based on Q1-2022 Payer Policies. Subject to Change
See an error? Let us know at ccteam@mct2d.org
Last Updated: 2022-April 28

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Download this coverage table: https://michmed.org/Mx2M3

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Questions?

What resources do you want / need to enhance your care of patients with T2D and obesity?

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FOR TYPE 2 DIABETES

References

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6. Caroline M. Apovian, Louis J. Aronne, Daniel H. Bessesen, Marie E. McDonnell, M. Hassan Murad, Uberto Pagotto, Donna H. Ryan, Christopher D. Still, Pharmacological Management of Obesity: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 100, Issue 2, 1 February 2015, Pages 342–362,
7. Lean MEJ, Leslie WS, Barnes AC, Brosnahan N, Thom G, McCombie L, Peters C, Zhyzhneuskaya S, Al-Mrabeh A, Hollingsworth KG, Rodrigues AM, Rehackova L, Adamson AJ, Sniehotta FF, Mathers JC, Ross HM, McIlvenna Y, Welsh P, Kean S, Ford I, McConnachie A, Messow CM, Sattar N, Taylor R. Durability of a primary care-led weight-management intervention for remission of type 2 diabetes: 2-year results of the DiRECT open-label, cluster-randomised trial. Lancet Diabetes Endocrinol. 2019 May;7(5):344-355.

Extra Slides

OFF LABEL: Phentermine and Topiramate

Phentermine 15 mg capsules
Phentermine 37.5mg tablets
one-half tablet (18.75 mg)

Topiramate 25 mg, 50 mg
Topiramate ER 50 mg

Start Phentermine 15 or 18.75 mg PO QAM
Add Topiramate 25 mg PO QHS X 2weeks

Qsymia 3.75/23 mg

Continue Phentermine 15/18.75 mg PO QAM
Increase Topiramate to 25 mg PO BID
OR
Switch to Topiramate ER 50 mg QD

Qsymia 7.5/46 mg

Continue Phentermine 15/18.75 mg PO QAM
Increase Topiramate to 50 mg PO BID
OR
Switch to Topiramate ER 100 mg QD

Qsymia 15/92 mg

Winkelman 2020

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OFF LABEL: Bupropion and Naltrexone

Bupropion SR 150 mg tablets
Bupropion XL 150/300 mg tablets

Naltrexone 50 mg tablets

Start bupropion SR 150 mg QD for 2 weeks
Increase bupropion SR 150 mg BID
OR
Start bupropion XL 150 QD for 4 weeks
Increase bupropion XL to 300 mg QD

Then add on:
Naltrexone 12.5 mg (1/4 tab) QD for 2 weeks
Increase to 12.5 mg (1/4 tab) BID for 2 weeks
Increase to 25 mg BID r 50 mg QD if tolerated

Contrave 8/90mg tab ~ Naltrexone 12.5 mg + 150mg Bupropion 150 mg tab

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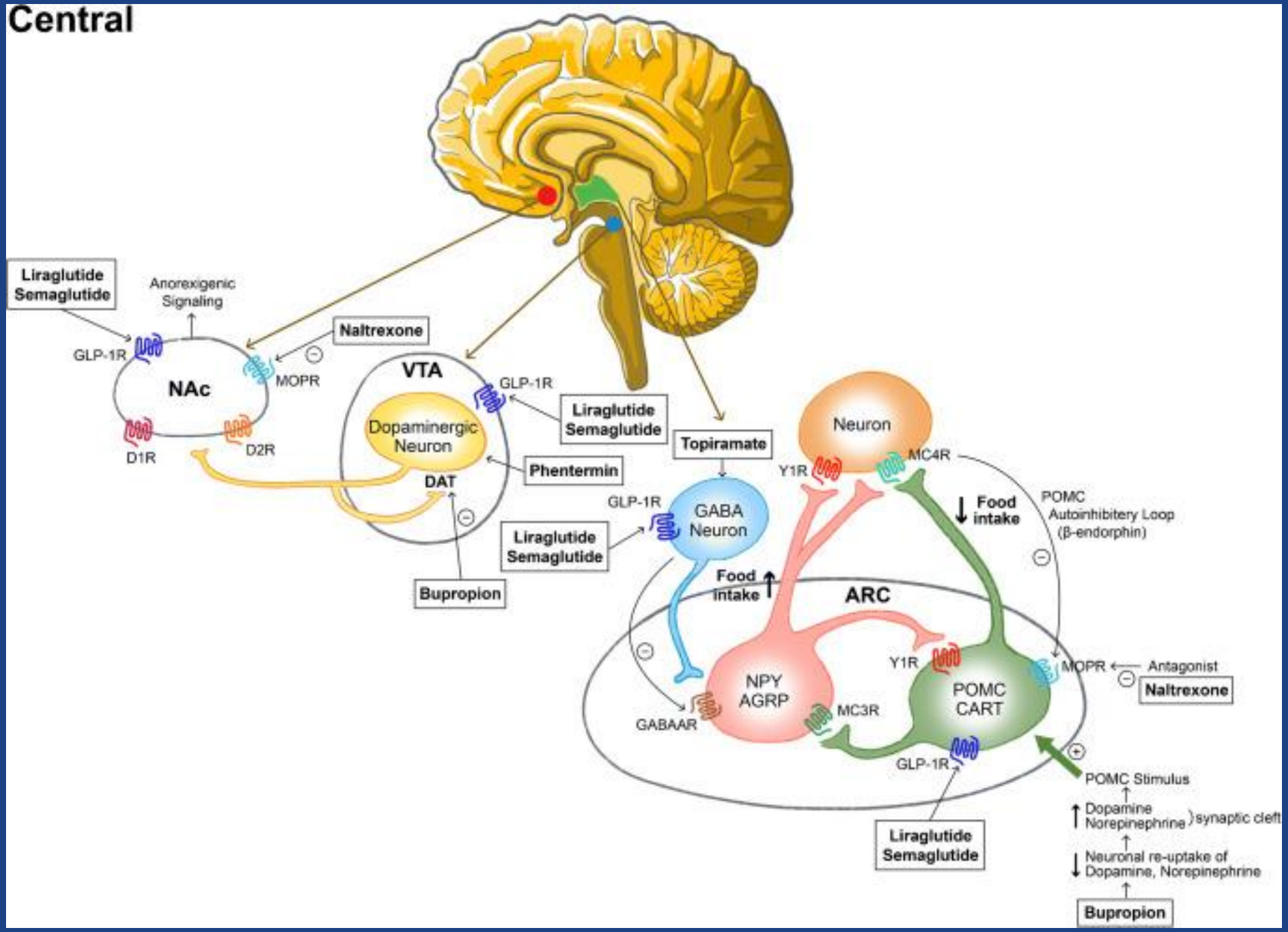
FOR TYPE 2 DIABETES

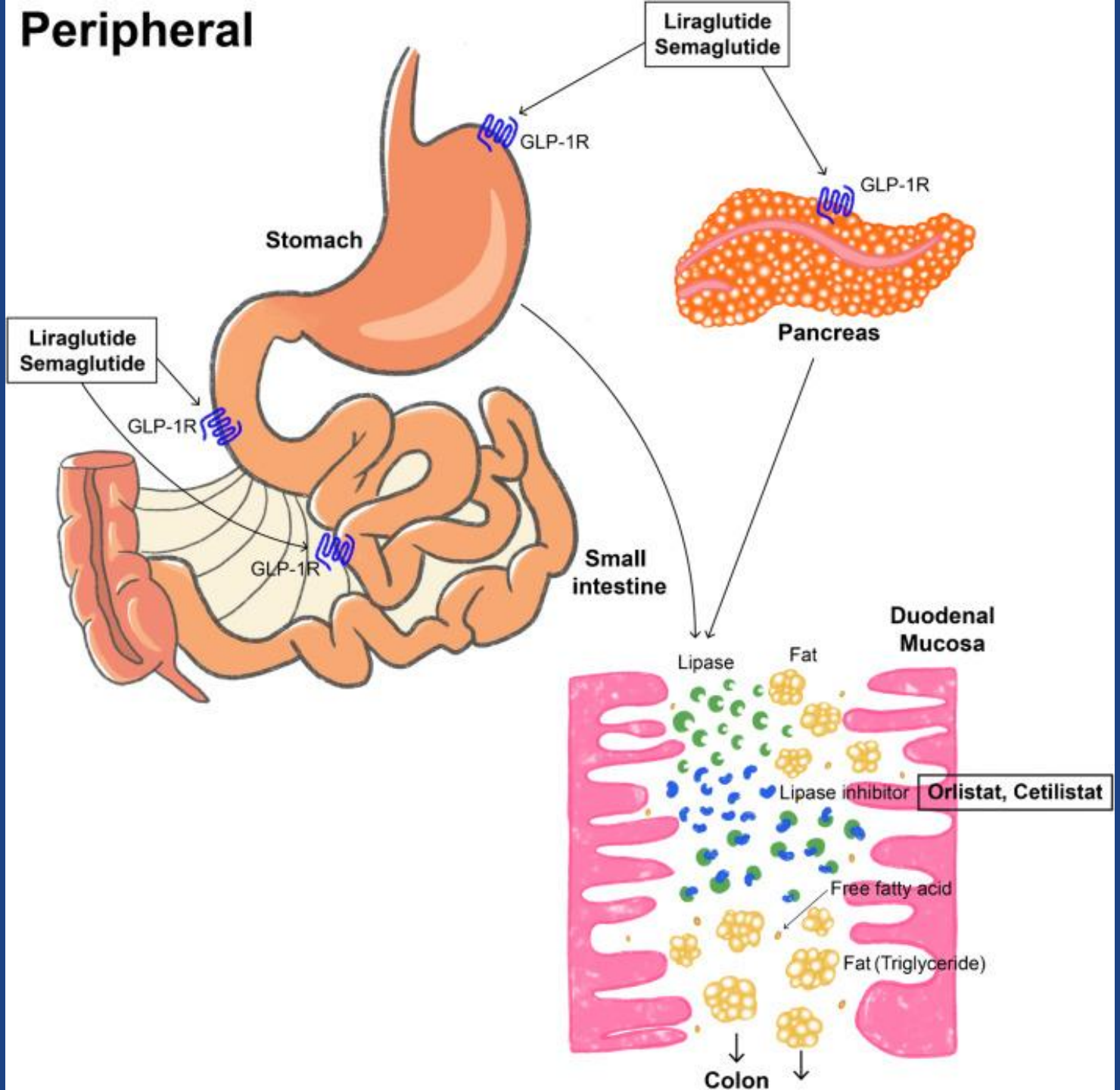
The Body Defends a Weight Set Point

Behavior drives physiology

Physiology drives behavior


Central
Liraglutide
Semaglutide
Anorexigenic
Signaling
GLP-1R
NAc
MOPR
Naltrexone
D1R
D2R
VTA
GLP-1R
Dopaminergic
Neuron
DAT
Liraglutide
Semaglutide
Phentermin
Bupropion
Topiramate
GLP-1R
GABA
Neuron
Liraglutide
Semaglutide
Food
intake
Neuron
Y1R
MC4R
Food
intake
POMC
Autoinhibitery Loop
(β-endorphin)
ARC
NPY
AGRP
GABAAR
MC3R
Y1R
POMC
CART
MOPR
Antagonist
Naltrexone
GLP-1R
Liraglutide
Semaglutide
POMC Stimulus
Dopamine
Norepinephrine
synaptic cleft
Neuronal re-uptake of
Dopamine, Norepinephrine
Bupropion

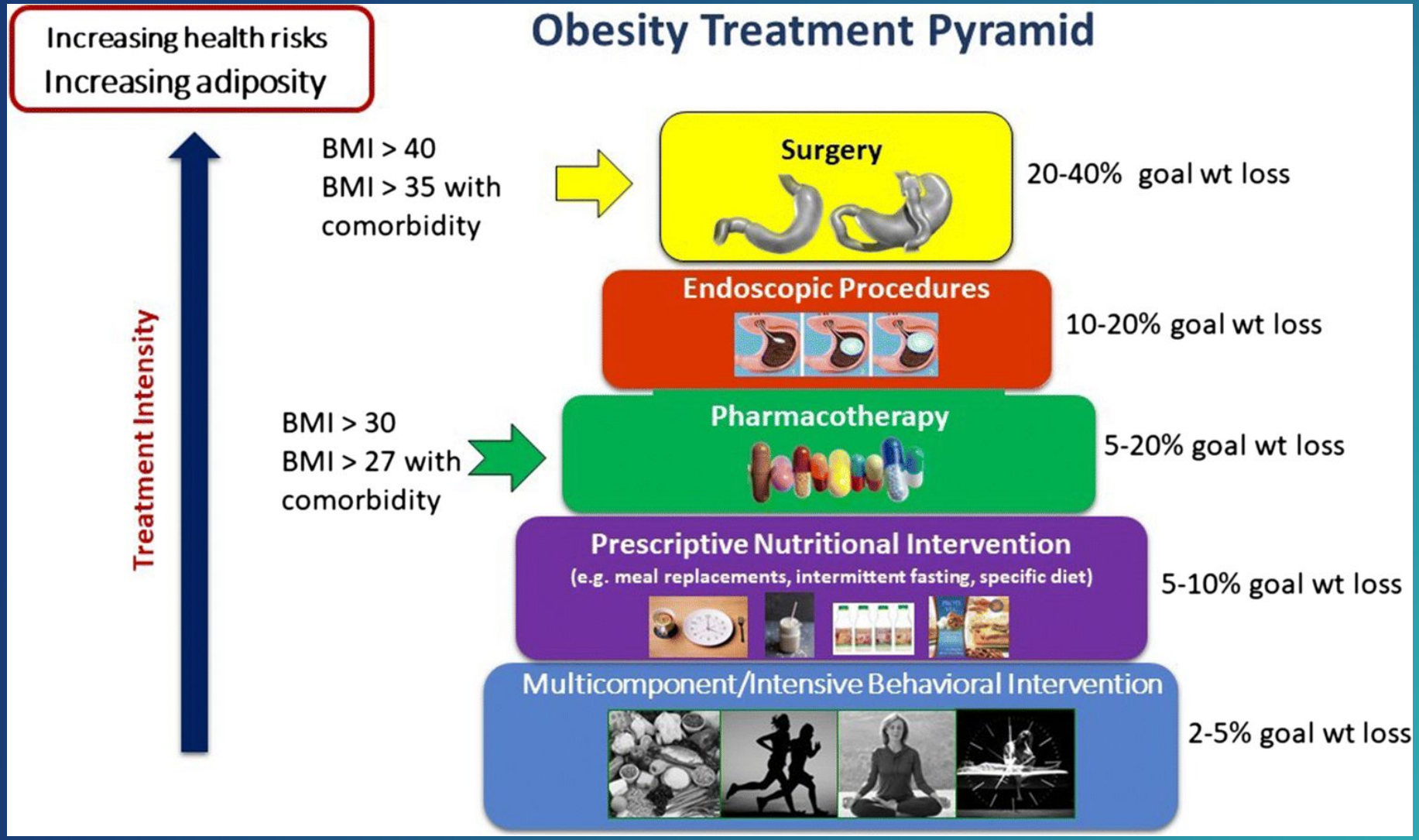
Tak 2021


Peripheral
Liraglutide
Semaglutide
GLP-1R
Stomach
GLP-1R
Pancreas
Liraglutide
Semaglutide
GLP-1R
GLP-1R
Small
intestine
Duodenal
Mucosa
Lipase
Fat
Lipase inhibitor
Orlistat, Cetilistat
Free fatty acid
Fat (Triglyceride)
Colon

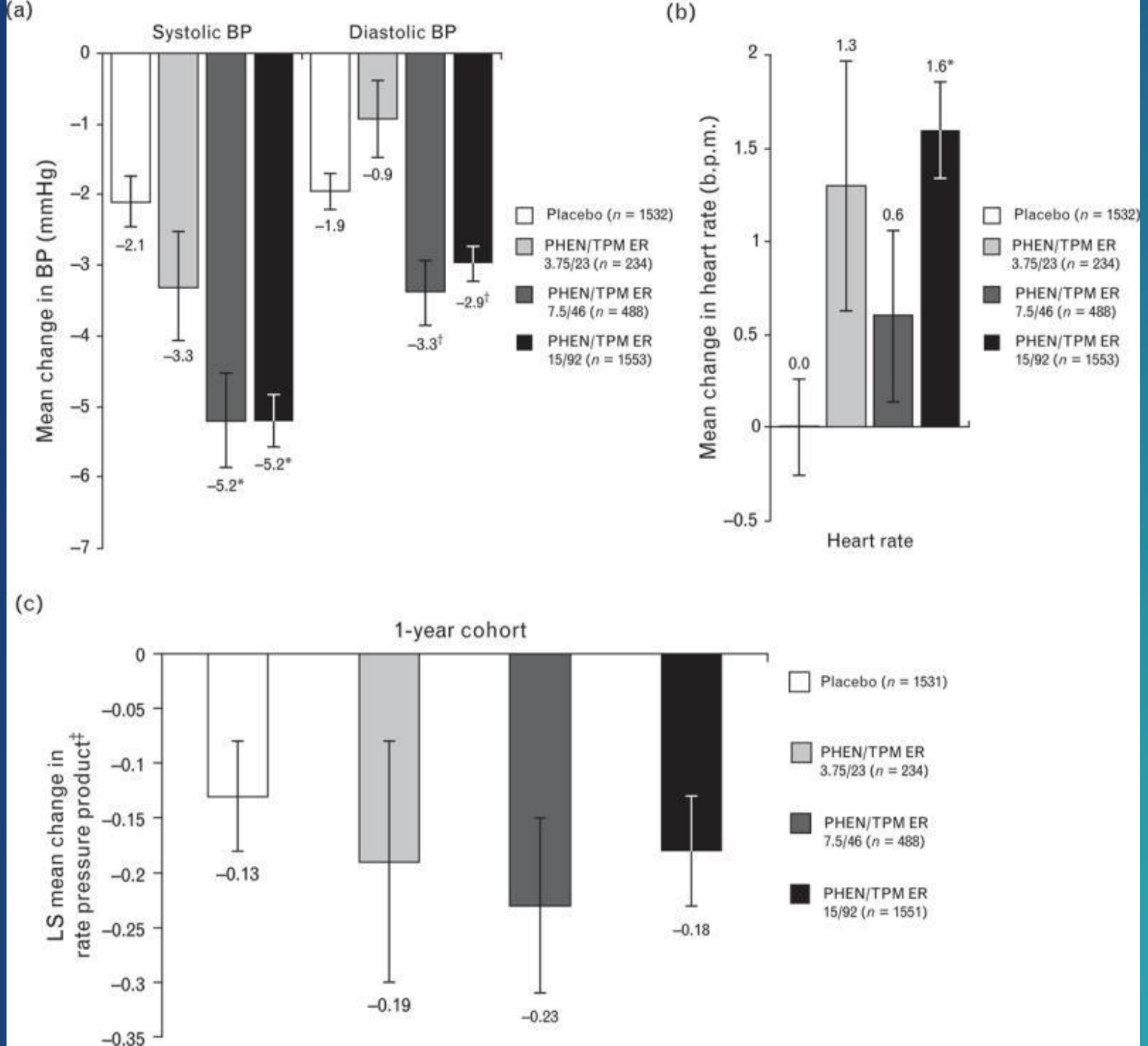
Selecting Anti-Obesity Medications

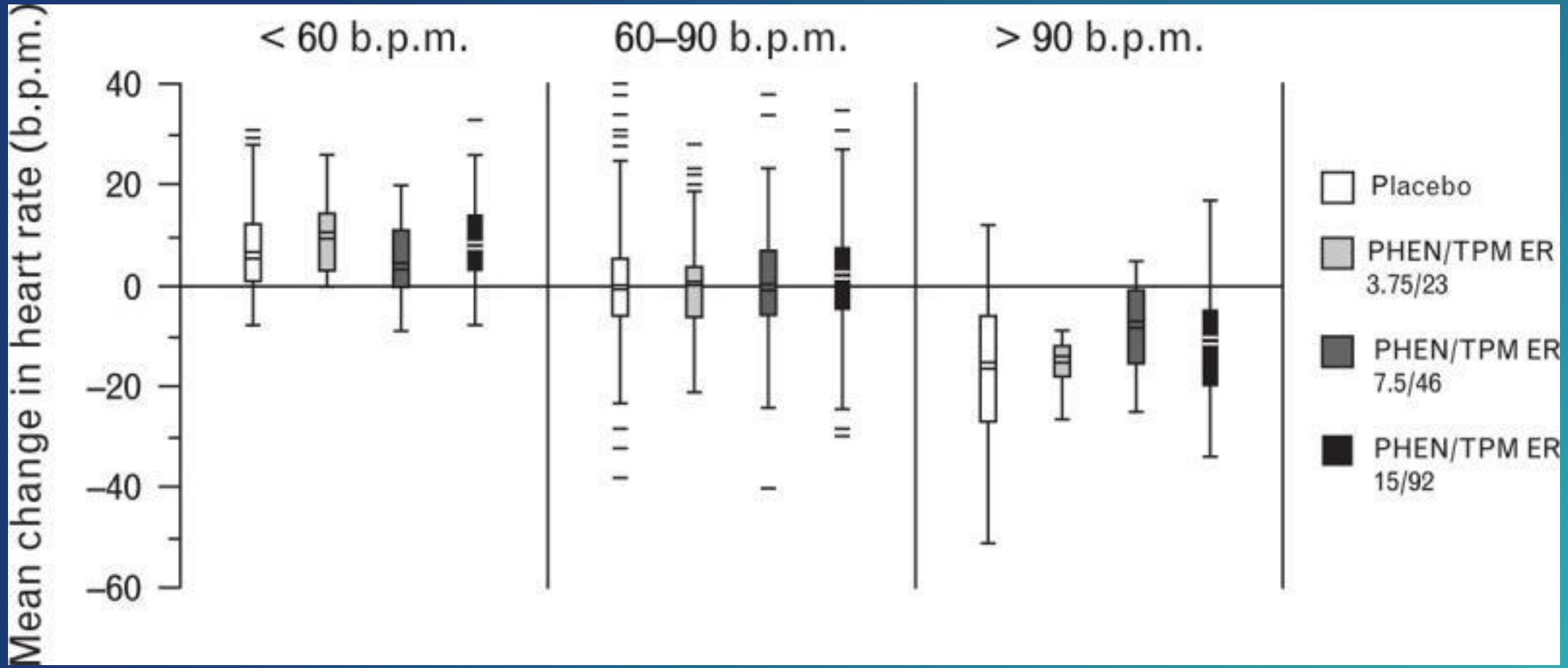
- Safety – contraindications and precautions
- Tolerability - side effect profile
- Efficacy
- Preferences – out of pocket cost and regimen
- Dual benefits – double benefit for a co-occurring disorder or risk factor.

Stepped Treatment Recommendations for Obesity



Tucker 2021


(a)
Systolic BP
Diastolic BP
Mean change in BP (mmHg)
0
–1
–2
–3
–4
–5
–6
–7
–2.1
–3.3
–5.2*
–5.2*
–1.9
–0.9
–3.3†
–2.9†
Placebo (n = 1532)
PHEN/TPM ER 3.75/23 (n = 234)
PHEN/TPM ER 7.5/46 (n = 488)
PHEN/TPM ER 15/92 (n = 1553)
(b)
Mean change in heart rate (b.p.m.)
2
1.5
1
0.5
0
–0.5
0.0
1.3
0.6
1.6*
Heart rate
Placebo (n = 1532)
PHEN/TPM ER 3.75/23 (n = 234)
PHEN/TPM ER 7.5/46 (n = 488)
PHEN/TPM ER 15/92 (n = 1553)
(c)
1-year cohort
LS mean change in rate pressure product‡
0
–0.05
–0.1
–0.15
–0.2
–0.25
–0.3
–0.35
–0.13
–0.19
–0.23
–0.18
Placebo (n = 1531)
PHEN/TPM ER 3.75/23 (n = 234)
PHEN/TPM ER 7.5/46 (n = 488)
PHEN/TPM ER 15/92 (n = 1551)


< 60 b.p.m.
60–90 b.p.m.
> 90 b.p.m.
Mean change in heart rate (b.p.m.)
40
20
0
–20
–40
–60
Placebo
PHEN/TPM ER 3.75/23
PHEN/TPM ER 7.5/46
PHEN/TPM ER 15/92