Drug Coverage Policy

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Policy Title….Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35

Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35

- Saxenda® (liraglutide subcutaneous injection – Novo Nordisk)
- Wegovy® (semaglutide subcutaneous injection – Novo Nordisk)
- Zepbound® (tirzepatide subcutaneous injection - Eli Lilly)

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medical necessity and other coverage determinations.

Overview
Saxenda, Wegovy, and Zepbound are glucagon-like peptide-1 (GLP-1) receptor agonists; Zepbound is also a glucose-dependent insulinotropic polypeptide (GIP) receptor agonist.[1-3]

Saxenda is indicated as an adjunct to a reduced-calorie diet and increased physical activity for **chronic weight management** in the following settings:[2]

- Adults with an initial body mass index (BMI) ≥ 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[2,3], dyslipidemia[2,3], type 2 diabetes[2,3], obstructive sleep apnea3, or cardiovascular disease[3]).
- Pediatric patients ≥ 12 years of age with body weight > 60 kg and an initial BMI corresponding to 30 kg/m^2 for adults (obese) by international cutoffs.

Wegovy and Zepbound are indicated in combination with a reduced-calorie diet and increased physical activity:[1,3]

- To **reduce excess body weight and maintain weight reduction long term** in:
  - **Wegovy and Zepbound:** Adults with overweight in the presence of at least one weight-related comorbid condition.[1,3]
  - **Wegovy and Zepbound:** Adults with obesity.[1,3]
  - **Wegovy:** Pediatric patients ≥ 12 years of age.[1]

Wegovy is also indicated in combination with a reduced-calorie diet and increased physical activity:[1]

- To **reduce the risk of major adverse cardiovascular (CV) events** (CV death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established CV disease and either obesity or overweight.[1]

Zepbound is indicated in combination with a reduced-calorie diet and increased physical activity:[3]

- To treat **moderate to severe obstructive sleep apnea** (OSA) in adults with obesity.

According to the Centers for Disease Control and Prevention (CDC), in adults, obesity is frequently subdivided into three categories:[4]

- **Class 1:** BMI ≥ 30 to < 35 kg/m^2
- **Class 2:** BMI ≥ 35 to < 40 kg/m^2
- **Class 3:** BMI ≥ 40 kg/m^2

In pediatric patients the CDC classifies obesity as a BMI ≥ 95th percentile.[5]

Guidelines from the American Academy of Pediatrics on evaluation and treatment of children and adolescents with obesity (2023) note that pediatricians and other primary health care providers should offer adolescents ≥ 12 years of age with obesity (BMI ≥ 95th percentile) weight loss

pharmacotherapy, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment.[6]

Dosing
In the prescribing information for Wegovy, a recommended dose escalation schedule of 16 weeks is outlined.[1] If a patient does not tolerate a dose during dose escalation, consider delaying dose escalation for 4 weeks. In adults the maintenance dose of Wegovy is 2.4 mg (recommended) or 1.7 mg injected subcutaneously once weekly (QW); consider treatment response and tolerability when selecting the maintenance dose. In pediatric patients, the maintenance dose of Wegovy is 2.4 mg; if a pediatric patient ≥ 12 to < 18 years of age does not tolerate the maintenance dose of 2.4 mg QW, the dose can be reduced to 1.7 mg QW. Discontinue Wegovy if the patient cannot tolerate the 1.7 mg dose. The 0.25 mg, 0.5 mg, and 1 mg QW doses are initiation and escalation doses, they are not approved doses for chronic weight management.

In the prescribing information for Saxenda, a recommended dose escalation schedule of 4 weeks is outlined.[2] If a patient does not tolerate an increased dose during dose escalation, consider delaying dose escalation for approximately one additional week. For adults, the recommended maintenance dose of Saxenda is 3 mg once daily; discontinue Saxenda if the patient cannot tolerate the 3 mg dose. Additionally, for adults, the prescribing information states to evaluate the change in body weight 16 weeks after initiating Saxenda and discontinue Saxenda if the patient has not lost ≥ 4% of baseline body weight, since it is unlikely the patient will achieve and sustain clinically meaningful weight loss with continued treatment.

In the prescribing information for Zepbound, the recommended starting dose is 2.5 mg injected subcutaneously QW.[3] The 2.5 mg dose is for treatment initiation and is not intended for chronic weight management. After 4 weeks, the dose can be increased to 5 mg subcutaneously QW. The dose can then be increased in 2.5 mg increments, after at least 4 weeks on the current dose. The recommended maintenance doses for weight reduction and long-term maintenance are 5 mg, 10 mg, or 15 mg subcutaneously QW. The recommended maintenance dose in OSA is 10 mg or 15 mg subcutaneously QW. The treatment response and tolerability should be considered when selecting the maintenance dose. If a patient does not tolerate a maintenance dose, consider a lower maintenance dose. The maximum dose is 15 mg subcutaneously QW. The 5 mg, 10 mg, and 15 mg maintenance doses are reached after Week 4, Week 12, and Week 20, respectively.

None of the GLP-1 or GLP-1/GIP agonists are recommended for coadministration with other GLP-1 or GLP-1/GIP agonists.[1-3]

Clinical Efficacy
Secondary Prevention of MACE
SELECT was a randomized, double-blind, placebo-controlled, event-driven study that assessed Wegovy (2.4 mg QW) vs. placebo, when added to standard of care, for the secondary prevention of CV events in adults ≥ 45 years of age with BMI ≥ 27 kg/m^2 and established CV disease without diabetes (n = 17, 604).[7] Established CV disease was defined as one of the following: prior myocardial infarction, prior stroke (ischemic or hemorrhagic), and/or symptomatic peripheral arterial disease (as evidenced by intermittent claudication with ankle-brachial index < 0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease). Patients who developed diabetes during the study remained in the study and received treatment (excluding use of another GLP-1 agonist). Wegovy was titrated to reach the 2.4 mg maintenance dose over 16 weeks. However, if dose escalation led to unacceptable effects the dose escalation intervals could be extended, treatment could be paused, or maintenance doses < 2.4 mg QW could be used. Most patients were male (72%) and White (84%). The mean weight was 97 kg. The mean BMI was 33.3 kg/m^2; 28.5% of patients had a BMI of 27 to < 30 kg/m^2, 42.5% of patients had a BMI of 30 to < 35 kg/m^2, 19% of patients had a BMI of 35 to < 40 kg/m^2, 7% of

patients had a BMI of 40 kg/m^2 to < 45 kg/m^2, and just over 3% of patients had a BMI ≥ 45 kg/m^2. Very few patients (< 0.1%) were treated with weight-lowering pharmacotherapy at baseline (further detail is not available; however, concomitant GLP-1 agonist use was not allowed).[9] The mean hemoglobin A_{1c} (HbA_{1c}) was just over 5.7%; 67% of patients had an HbA_{1c} ≥ 5.7% (pre-diabetes). The most common prior CV event was myocardial infarction (68% of patients), followed by stroke (18%), and 4.5% of patients had symptomatic peripheral arterial disease; 8% of patients had two or more of these conditions. At baseline, 91.8% of patients were receiving CV risk-lowering pharmacotherapy, 90% of patients were receiving lipid-lowering agents (87.3% of patients were taking statins, 13.0% of patients were taking ezetimibe, 2.7% of patients were taking fibrates, and 2.0% of patients were taking proprotein convertase subtilisin/kexin type 9 inhibitors), 86.2% of patients were receiving platelet aggregation inhibitors, and 12.6% of patients were receiving antithrombotic medications.[7,9] In addition, 70.2% of patients were taking beta-blockers, 45.0% of patients were taking angiotensin converting enzyme inhibitors, and 29.5% of patients were taking angiotensin receptor blockers.[9] The primary efficacy endpoint was a composite of death from CV causes, non-fatal MI, or non-fatal stroke.[7] Confirmatory secondary endpoints, assessed in a time-to-first-event analysis and tested in hierarchical order were, death from CV causes, a composite heart failure endpoint (death from CV causes or hospitalization for heart failure [HHF] or an urgent medical visit for heart failure), and death form any cause. A gatekeeping approach was used with statistical significance at each step required in order to test the next hypothesis.

Results. Patients were followed for a mean of 39.8 months.[7] At Week 104, approximately 77% of patients receiving Wegovy were taking the target 2.4 mg QW dose (details on the exact proportions of patients on other Wegovy doses are not available; efficacy results are only provided for the 2.4 mg dose). The trial achieved its primary endpoint, demonstrating a statistically significant and superior reduction in MACE for Wegovy vs. placebo. A primary endpoint event occurred in 6.5% vs. 8.0% of patients in the Wegovy vs. placebo groups, respectively (hazard ratio [HR] 0.80; 95% confidence interval [CI]: 0.72, 0.90; P < 0.001). Death from CV events, the first confirmatory secondary endpoint, occurred in 2.5% vs. 3.0% of Wegovy- vs. placebo-treated patients, respectively (HR 0.85; 95% CI: 0.71, 1.01; P = not significant for superiority). Because the difference between groups for death from CV events did not meet the required P-value for superiority, testing was not performed for the remaining confirmatory and secondary endpoints. The mean change in body weight at Week 104 was -9.39% vs. -0.88% with Wegovy and placebo, respectively (estimated treatment difference -8.51%; 95% CI: -8.75%, -8.27%; no P-value provided).[7] Among patients with prediabetes at baseline (HbA_{1c} ≥ 5.7%), the odds of achieving a normal HbA_{1c} level (< 5.7%) by Week 104 were greater with Wegovy vs. placebo (65.7% [n = 3,775/5,750) vs. 21.4% [n = 1,211/5,663] of patients, respectively, achieved a normal HbA_{1c}; odds ratio 8.74; 95% CI: 7.91, 9.65; no P-value provided). Other secondary endpoints generally favored Wegovy at Week 104 (e.g., waist circumference, blood pressure, lipids).

OSA

The SURMOUNT-OSA (n = 469) [published] trials were two 52-week, Phase III, multicenter, double-blind, randomized trials that evaluated the efficacy and safety of maximally tolerated Zepbound (10 mg or 15 mg QW) in adults with obesity (without diabetes) and moderate to severe OSA.[10] ***Inclusion/exclusion.*** Two patient populations were included. In Trial 1, patients were unable or unwilling to use positive airway pressure (PAP) therapy, and in Trial 2, patients had been using PAP therapy for ≥ 3 months at the time of screening and planned to continue PAP therapy during the trial. All patients had a diagnosis of moderate to severe OSA with an apnea-hypopnea index (AHI) ≥ 15 events/hour as diagnosed with polysomnography, home sleep apnea test, or other method that met local guidelines prior to Visit 1. Patients had a BMI of ≥ 30 kg/m^2 (≥ 27 kg/m^2 in Japan) despite the history of at least one self-reported unsuccessful dietary effort to lose weight. Key exclusion criteria were the presence of type 1 or type 2 diabetes (HbA_{1c} ≥

6.5% at Visit 1), change in weight of > 5 kg in the past 3 months, planned surgery for sleep apnea or obesity, diagnosis of central or mixed sleep apnea with the percentage of mixed or central apneas/hypopneas ≥ 50%, or diagnosis of Cheyne Stokes respiration, diagnosis of obesity hypoventilation syndrome or daytime hypocapnia, active device treatment of OSA other than PAP therapy (e.g., dental appliance), and major craniofacial abnormalities that may affect breathing. In addition, use of medications (prescribed or over-the-counter) or alternative remedies to promote weight loss in the past 3 months were not allowed, this included other GLP-1 agonists. Of note, although patients with diabetes at baseline were excluded, if a patient developed diabetes while in the study, the patient was referred to their usual care provider. The decision to further evaluate, to initiate antihyperglycemic therapy, and the choice of antihyperglycemic medication was at the discretion of the provider.

Study design. Following a 4-week screening period, patients were assigned to Trial 1 or Trial 2 and randomly assigned to receive Zepbound or placebo SC QW.[10] All patients received regular lifestyle counseling sessions focused on the maintenance of healthy nutrition, adherence to a 500 calorie/day deficit, and ≥ 150 minutes per week of physical activity. The dose of Zepbound was escalated over a period of up to 20 weeks starting at 2.5 mg SC QW and increased by 2.5 mg every 4 weeks during the dose-escalation period until the patient reached the maximum tolerated dose of 10 mg or 15 mg SC QW at Week 20. Dose modification was permitted for the management of intolerable GI symptoms. Patients who did not tolerate ≥ 10 mg even after one de-escalation and re-escalation attempt, were discontinued from the study intervention but remained in the study for continued follow-up. During the first 24 weeks of the treatment period (20-week dose escalation plus 4 weeks), participants unable to tolerate 2.5 mg or 5 mg were discontinued from the study intervention but remained in the study. For patients unable to tolerate any dose escalation between 7.5 mg and 15 mg (inclusive), a dose de-escalation step with subsequent re-escalation by 2.5 mg every 4 weeks up to the maximum tolerated dose was allowed in a blinded fashion, to reach either the 10 mg or 15 mg dose. Only one cycle of dose de-escalation and re-escalation was permitted during the first 24 weeks of the treatment period. The 10 mg maintenance dose was used in patients who tolerated 10 mg, but not 12.5 mg or 15 mg even following one de-escalation and re-escalation attempt. In addition, patients who tolerated 12.5 mg, but not 15 mg even after one de-escalation and re-escalation attempt, continued 10 mg as their maximum tolerated dose. Patients who tolerated 15 mg continued 15 mg as their maximum tolerated dose. ***Endpoints.*** The primary endpoint was the superiority of Zepbound vs. placebo for the change in the AHI from baseline. Several key secondary endpoints were assessed including the proportion of patients with an AHI reduction of ≥ 50%, the proportion of patients with an AHI of < 5 events/hour or with an AHI of 5 to 14 events/hour and a score of ≤ 10 on the Epworth Sleepiness Scale (ESS; scores range from 0 to 24 with higher scores indicating greater daytime sleepiness), percent change in body weight, change in high-sensitivity C-reactive protein (hsCRP), change in sleep apnea specific hypoxic burden, changes in patient reported outcome measures, and the change in systolic blood pressure. The primary endpoint was assessed using the treatment-regimen estimand (average treatment effect of Zepbound relative to placebo for all patients who had received at least one dose of Zepbound or placebo regardless of ether they discontinued trial treatment for any reason). ***Baseline characteristics.*** In Trial 1, the mean age was 47.9 years, most patients were male (67.1% of patients) and White (65.8% of patients); 41.9% of patients were Hispanic or Latino, 10.1% of patients were Asian, 7.7% of patients were American Indian or Alaska Native, and 5.6% of patients were Black or African American. The mean BMI was 39.1 kg/m^2 and the mean AHI was 51.5 events/hour. Most patients had severe OSA (63%). In Trial 2, the mean age was 51.7 years, most patients were male (72.3% of patients) and White (73.1% of patients); 32.3% of patients were Hispanic or Latino, 14.1% of patients were Asian, 8.1% of patients were American Indian or Alaska Native, and 4.7% of patients were Black or African American. The mean BMI was 38.7 kg/m^2 and the mean AHI was 49.5 events/hour. Most patients had severe OSA (68%).

Results. In both trials, Zepbound was superior to placebo for the primary endpoint.[10] In Trial 1, the change in AHI at Week 52 with Zepbound was superior to placebo (-25.3 events/hour [95% CI: -29.3, -21.2] vs. -5.3 events/hour [95% confidence interval [CI]: -9.4, -1.1]), respectively; estimated treatment difference of -20.0 events/hour; 95% CI: -25.8, -14.2; P < 0.001). In Trial 2, the change in AHI at Week 52 with Zepbound was superior to placebo (-29.3 events/hour [95% CI: -33.2, -25.4] vs. -5.5 events/hour [95% CI: -9.9, -1.2]; estimated treatment difference -23.8 events/hour; 95% CI: -26.9, -17.9; P < 0.001). Additionally, patients in both trials who received Zepbound had significant reductions in sleep apnea-specific hypoxic burden. The proportion of patients with a reduction in the AHI of ≥ 50% at Week 52 and the proportion of patients with an AHI of < 5 events/hour or an AHI of 5 to 14 events/hour and an ESS of ≤ 10 at Week 52 also favored Zepbound. Patients receiving Zepbound in both trials had significant reductions in body weight, systolic blood pressure, and hsCRP concentrations as well.

Guidelines

Sleep Apnea

The American Academy of Sleep Medicine (2017) recommends that diagnostic testing for obstructive sleep apnea (OSA) be performed in combination with a comprehensive sleep evaluation.[11] Polysomnography is the standard diagnostic test for the diagnosis of OSA in adults in whom there is concern for OSA based on the sleep evaluation. Polysomnography is accepted as the gold standard test for the diagnosis of OSA. In some cases, and within the appropriate context, the use of home sleep apnea test as the initial sleep study may be acceptable, however, polysomnography should be used when home sleep apnea test results does not provide satisfactory posttest probability of confirming or ruling out OSA.

Available treatment guidelines for OSA do not specifically mention the GLP-1 agonists. The American Thoracic Society clinical practice guideline on the role of weight management in the treatment with adults with OSA (2018) recommend patients with OSA who are overweight or obese (BMI ≥ 25 kg/m^2) participate in comprehensive lifestyle intervention that includes a reduced calorie diet, exercise/increased physical activity, and behavioral counseling.[12] For patients with OSA and a BMI ≥ 27 kg/m^2 who have not had an improvement in weight despite a comprehensive weight-loss lifestyle program, and have no contraindications (no active CV disease), evaluation for anti-obesity medication is suggested. The guideline also cites agreement with the American Association of Clinical Endocrinologists and the American College of Endocrinology guidelines (2016) which state the weight-loss goal in patients with overweight or obesity with OSA should be at least ≥ 7% to 11% of total body weight.[12] In patients with a BMI ≥ 35 kg/m^{2}referral for bariatric surgery evaluation is suggested.

The American College of Physicians clinical practice guideline for the management of OSA (2013) recommend that all overweight and obese patients diagnosed with OSA be encouraged to lose weight.[13] Continuous positive airway pressure (PAP) is recommended as initial therapy for patients with OSA. Mandibular advancement devices are recommended for patients with OSA who prefer such devices or for those with adverse events associated with continuous PAP treatment.

Clinical success in OSA has been described by several publications. The American Academy of Sleep Medicine (2019) cites a clinically significant threshold of ≥ 15 events/hour (on AHI)[14] and a clinical practice guideline for the treatment of OSA and snoring with oral appliance therapy (2015) from the American Academy of Sleep Medicine and American Academy of Dental Sleep Medicine[15] note that treatment success has usually defined as a reduction in the AHI to a specific level (e.g., post-treatment AHI < 5 events/hour, or a > 50% reduction in AHI). Of note, a meta-analysis on the impact of weight reduction on AHI reported that weight reduction in patients with obesity and OSA was associated with improvements in the severity of OSA. A BMI reduction of 20% was associated with an AHI reduction of 57%; further weight reduction beyond 20% in BMI was associated with a smaller effect on AHI.[16]

Coverage Policy

Policy Statement
This Benefit Exclusion Overrides policy has been developed to authorize coverage of the targeted drugs for the treatment of weight loss in adults with a body mass index (BMI) of ≥ 27 kg/m^2 with at least two weight-related comorbidities or with a body mass index of ≥ 35 kg/m^2 and for pediatric patients with a patient a BMI ≥ 95th percentile for age and sex (see authorization criteria for details). The BMI thresholds for the weight loss indications in adults are not based on clinical data and but are provided in this product offering to allow a subset of patients to obtain these medications. Additionally, the policy authorizes coverage of Wegovy to reduce the risk of major adverse cardiovascular event(s) in a patient with established cardiovascular disease who is either obese or overweight (see authorization criteria for details) and Zepbound to treat moderate to severe obstructive sleep apnea in a patient with obesity (see authorization criteria for details). All approvals are provided for the duration noted below.

I. Saxenda is considered medically necessary when ONE of the following is met (1 or 2):

FDA-Approved Indications

1. **Weight Loss, Adult.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 4 months if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months; AND
     - **iii.** Patient meets ONE of the following (a or b):
       - **a)** At baseline, patient had a BMI ≥ 35 kg/m^2; OR
         Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
       - **b)** Patient meets BOTH of the following [(1) and (2)]:
         (1) At baseline, patient had a BMI ≥ 27 kg/m^2; AND
         (2) At baseline, patient had, or patient currently has, at least TWO of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND
         Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
     - **iv.** The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR
   - **B)** Patient is Continuing Therapy with Saxenda. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
     Note: For a patient who has not completed 4 months of initial therapy, refer to Initial Therapy criteria above.

i. Patient is ≥ 18 years of age; AND

ii. Patient meets ONE of the following (a or b):

a) At baseline, patient had a BMI ≥ 35 kg/m^2; OR
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

b) Patient meets BOTH of the following [(1) and (2)]:

(1) At baseline, patient had a BMI ≥ 27 kg/m^2; AND

(2) At baseline, patient had, or patient currently has, at least TWO of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND

Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iii. Patient has lost ≥ 4% of baseline body weight; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

2. Weight Loss, Pediatric. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 4 months if the patient meets ALL of the following (i, ii, iii, and iv):

i. Patient is ≥ 12 years of age and < 18 years of age; AND

ii. Patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months; AND

iii. At baseline, patient had a BMI ≥ 95th percentile for age and sex; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR

B) Patient is Continuing Therapy with Saxenda. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
Note: For a patient who has not completed 4 months of initial therapy, refer to Initial Therapy criteria above.

i. Patient is ≥ 12 years of age and < 18 years of age; AND

ii. At baseline, patient had a BMI ≥ 95th percentile for age and sex; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iii. Patient has had a reduction in BMI of ≥ 1% from baseline; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

II. Wegovy is considered medically necessary when ONE of the following is met (1, 2, or 3):

FDA-Approved Indications

1. **Weight Loss, Adult.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 7 months if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months; AND
     - **iii.** Patient meets ONE of the following (a or b):
       - **a)** At baseline, patient had a BMI ≥ 35 kg/m^2; OR
         Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
       - **b)** Patient meets BOTH of the following [(1) and (2)]:
         (1) At baseline, patient had a BMI ≥ 27 kg/m^2; AND
         (2) At baseline, patient had, or patient currently has, at least TWO of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND
         Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
     - **iv.** The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR
   - **B)** Patient is Continuing Therapy with Wegovy. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
     Note: For a patient who has not completed 7 months of initial therapy, refer to Initial Therapy criteria above.
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient meets ONE of the following (a or b):
       - **a)** At baseline, patient had a BMI ≥ 35 kg/m^2; OR
         Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
       - **b)** Patient meets BOTH of the following [(1) and (2)]:
         (1) At baseline, patient had a BMI ≥ 27 kg/m^2; AND
         (2) At baseline, patient had, or patient currently has, at least TWO of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-

dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND

Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iii. Patient has lost ≥ 5% of baseline body weight; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

2. **Weight Loss, Pediatric.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   A) Initial Therapy. Approve for 7 months if the patient meets ALL of the following (i, ii, iii, and iv):
      i. Patient is ≥ 12 years of age and < 18 years of age; AND
      ii. Patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months; AND
      iii. At baseline, patient had a BMI ≥ 95th percentile for age and sex; AND
      Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
      iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR
   B) Patient is Continuing Therapy with Wegovy. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
      Note: For a patient who has not completed 7 months of initial therapy, refer to Initial Therapy criteria above.
      i. Patient is ≥ 12 years of age and < 18 years of age; AND
      ii. At baseline, patient had a BMI ≥ 95th percentile for age and sex; AND
      Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
      iii. Patient has had a reduction in BMI of ≥ 1% from baseline; AND
      Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
      iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

3. **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease who is Either Obese or Overweight.** Approve for 1 year if the patient meets ONE of the following (A or B):
   A) Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, iv, and v):
      i. Patient is ≥ 18 years of age; AND
      ii. Patient has a current BMI ≥ 27 kg/m^2; AND
      iii. Patient meets ONE of the following (a, b, or c):
         a) Patient has had a prior myocardial infarction; OR

b) Patient has had a prior stroke; OR
c) Patient has a history of symptomatic peripheral arterial disease as evidenced by ONE of the following [(1), (2), or (3)]:
(1) Intermittent claudication with ankle-brachial index < 0.85; OR
(2) Peripheral arterial revascularization procedure; OR
(3) Amputation due to atherosclerotic disease; AND

iv. According to the prescriber, the medication will be used in combination with optimized pharmacotherapy for established cardiovascular disease; AND
v. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR

B) Patient is Continuing Therapy with Wegovy. Approve if the patient meets ALL of the following (i, ii, iii, iv, and v):
Note: For a patient who has not completed 1 year of initial therapy, refer to Initial Therapy criteria above.
i. Patient is ≥ 18 years of age; AND
ii. At baseline, patient had a BMI ≥ 27 kg/m^2; AND
Note: This refers to baseline prior to Wegovy.
iii. Patient meets ONE of the following (a, b, or c):
a) Patient has had a prior myocardial infarction; OR
b) Patient has had a prior stroke; OR
c) Patient has a history of symptomatic peripheral arterial disease as evidenced by ONE of the following [(1), (2), or (3)]:
(1) Intermittent claudication with ankle-brachial index < 0.85; OR
(2) Peripheral arterial revascularization procedure; OR
(3) Amputation due to atherosclerotic disease; AND

iv. According to the prescriber, the medication will be used in combination with optimized pharmacotherapy for established cardiovascular disease; AND
v. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

III. Zepbound is considered medically necessary when ONE of the following is met (1 or 2):

FDA-Approved Indications

1. **Weight Loss, Adult.** Approve for the duration noted if the patient meets ONE of the following (A or B):
A) Initial Therapy. Approve for 8 months if the patient meets ALL of the following (i, ii, iii, and iv):
i. Patient is ≥ 18 years of age; AND
ii. Patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months; AND
iii. Patient meets ONE of the following (a or b):
a) At baseline, patient had a BMI ≥ 35 kg/m^2; OR
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
b) Patient meets BOTH of the following [(1) and (2)]:
(1) At baseline, patient had a BMI ≥ 27 kg/m^2; AND

(2) At baseline, patient had, or patient currently has, at least TWO of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR

B) Patient is Continuing Therapy with Zepbound. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
Note: For a patient who has not completed 8 months of initial therapy, refer to Initial Therapy criteria above.

i. Patient is ≥ 18 years of age; AND

ii. Patient meets ONE of the following (a or b):

a) At baseline, patient had a BMI ≥ 35 kg/m^2; OR
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

b) Patient meets BOTH of the following [(1) and (2)]:
(1) At baseline, patient had a BMI ≥ 27 kg/m^2; AND
(2) At baseline, patient had, or patient currently has, at least TWO of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iii. Patient has lost ≥ 5% of baseline body weight; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

2. Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.
Approve for 1 year if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, iv, and v):

i. Patient is ≥ 18 years of age; AND

ii. Patient has a current BMI ≥ 30 kg/m^2; AND

iii. Patient has had a sleep study within the past 1 year that shows BOTH of the following (a and b):

a) Patient has been diagnosed with moderate to severe obstructive sleep apnea; AND

b) Patient has an apnea-hypopnea index ≥ 15 events per hour; AND

Note: A diagnosis of moderate obstructive sleep apnea is an apnea-hypopnea index of ≥ 15 events per hour, a diagnosis of severe sleep apnea is an apnea-hypopnea index ≥ 30 events per hour. The apnea-hypopnea index is the number of apneas and hypopneas during 1 hour of sleep.

iv. The patient does NOT meet either of the following (a or b):
Note: A patient who has one or more of the following conditions/diagnoses below is not approved.
a) Central sleep apnea with percent of central apneas/hypopneas ≥ 50%; OR
b) Cheyne Stokes respiration; OR

v. The medication will be used in concomitantly with behavioral modification and a reduced-calorie diet; OR

B) Patient is Continuing Therapy with Zepbound. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
Note: For a patient who has not completed 1 year of initial therapy, refer to Initial Therapy criteria above.

i. Patient is ≥ 18 years of age; AND

ii. At baseline, patient had a BMI ≥ 30 kg/m^2; AND
Note: This refers to baseline before Zepbound.

iii. Patient has completed ≥ 1 year of therapy with Zepbound AND the patient meets BOTH of the following (a and b):
a) Patient has lost ≥ 10% of baseline body weight; AND
Note: This refers to baseline prior to Zepbound.
b) Patient has stability in obstructive sleep apnea signs or symptoms, according to the prescriber; AND
Note: Examples of signs or symptoms of obstructive sleep apnea include but are not limited to snoring, excessive daytime sleepiness, fatigue.

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Saxenda, Wegovy, and Zepbound for any other use are considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concomitant Use with Other Weight Loss Medications.** Concomitant use with other medications intended for weight loss is not recommended.[2,3,8] Note: Examples of other medications FDA-approved for weight loss include but are not limited to phentermine (Lomaira, generic), benzphetamine, diethylpropion, phendimetrazine, Contrave (naltrexone/bupropion extended-release tablets), Qsymia (phentermine/topiramate extended-release capsules), and Xenical (orlistat 120 mg capsules). Additionally, Alli (orlistat 60 mg capsules) is available over-the-counter.

2. **Concomitant Use with Glucagon-Like Peptide-1 (GLP-1) Agonists or GLP-1/ Glucose-Dependent Insulinotropic Polypeptide (GIP) Agonists.** The GLP-1 agonists and the GLP-1/GIP agonist should not be combined with each other or with any other GLP-

1 agonists or GLP-1/GIP agonist.[1,2,9] There are other GLP-1 and GLP-1/GIP products not included in this policy that are FDA-approved for type 2 diabetes, and not chronic weight management. Note: Examples of other GLP-1 agonists include but are not limited to Adlyxin (lixisenatide subcutaneous [SC] injection), Byetta (exenatide SC injection), Bydureon BCise (exenatide extended-release SC injectable suspension), Ozempic (semaglutide SC injection), Rybelsus (semaglutide tablets), Trulicity (dulaglutide SC injection), and liraglutide SC injection (Victoza, authorized generic). An example of a GLP-1/GIP agonist is Mounjaro (tirzepatide SC injection).

References

1. Wegovy® subcutaneous injection [prescribing information]. Plainsboro, NJ: Novo Nordisk; November 2024.
2. Saxenda® subcutaneous injection [prescribing information]. Plainsboro, NJ: Novo Nordisk; November 2024.
3. Zepbound® subcutaneous injection [prescribing information]. Indianapolis, IN: Eli Lilly; December 2024.
4. Centers for Disease Control and Prevention. Defining adult overweight and obesity. Available at: https://www.cdc.gov/bmi/adult-calculator/bmi-categories.html?CDC_AAref_Val=https://www.cdc.gov/obesity/basics/adult-defining.html. Accessed on: November 19, 2024.
5. Centers for Disease Control and Prevention. Defining child BMI categories. Available at: https://www.cdc.gov/bmi/child-teen-calculator/bmi-categories.html?CDC_AAref_Val=https://www.cdc.gov/obesity/basics/childhood-defining.html. Accessed on November 19, 2024.
6. Hampl SE, Hassink SG, Skinner AC, et al. Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity. *Pediatrics*. 2023;151(2):e2022060640.
7. Lincoff AM, Brown-Frandsen K, Colhoun HM, et al; for the SELECT Trial Investigators. Semaglutide and cardiovascular outcomes in obesity without diabetes. *N Engl J Med.* 2023;389(24):2221-2232.
8. Wilding JPH, Batterham RL, Calanna S, et al; STEP 1 Study Group. Once-weekly semaglutide in adults with overweight or obesity. *N Engl J Med*. 2021;384(11):989.
9. Lingvay I, Brown-Frandson K, Colhoun HM et al. Semaglutide for cardiovascular event reduction in people with overweight or obesity: SELECT study baseline characteristics. *Obesity.* 2023;31(1):111-122.
10. Malhorta A, Grunstein RR, Fietze I, et al; for the SURMOUNT-OSA Investigators. Tirzepatide for the treatment of obstructive sleep apnea and obesity. *N Engl J Med.* 2024;391(13):1193-1205.
11. Kapur VK, Auckley DH, Chowdhuri S, et al. Clinical practice guideline for diagnostic testing for adult obstructive sleep apnea: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med.* 2017;13(3):479-504.
12. Hudgel DW, Patel SR, Ahasic AM, et al; on behalf of the American Thoracic Society Assembly on Sleep and Respiratory Neurology. The role of weight management in the treatment of adult obstructive sleep apnea. *Am J Respir Crit Care Med.* 2018;198(6):e70-e87.
13. Qaseem A, Hotly JEC, Ownes DK, et al; for the Clinical Guidelines Committee of the American College of Physicians. Management of obstructive sleep apnea in adults: a clinical practice guideline from the American College of Physicians. *Ann Intern Med.* 2013;159:471-483.
14. Ramar K, Dort LC, Katz SG et al. Clinical practice guideline for the treatment of obstructive sleep apnea and snoring with oral appliance therapy: an update for 2015. An American Academy of Sleep Medicine and American Academy of Dental Sleep Medicine Clinical Practice Guideline. *J Clin Sleep Med.* 2015;11(7):773-827.

15. Patil SP, Ayappa IA, Caples SM, et al. Treatment of adult obstructive sleep apnea with positive airway pressure: An American Academy of Sleem Medicine Systematic Review, Meta-analysis, and GRADE Assessment. *J Clin Sleep Med.* 2019;15(2):301-334.
16. Malhorta A, Heilman CR, Banerjee, et al. Weight reduction and the impact on apnea-hypopnea index: a systematic meta-analysis. *Sleep Medicine.* 2023;121:26-31.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	07/01/2025

The policy effective date is in force until updated or retired.