Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 24, 2025	January 1, 2026	*See below

SUBJECT

Coverage Change and Prior Authorization of Obesity Treatment Agents – Pharmacy Services

BY

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IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.pa.gov/en/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents

PURPOSE:

The purpose of this bulletin is to:

1. Inform providers that effective January 1, 2026, coverage will end for drugs containing a glucagon-like peptide-1 (GLP-1) receptor agonist for the treatment of overweight and obesity for Medical Assistance (MA) beneficiaries.
2. Inform providers that Obesity Treatment Agents that do not contain a GLP-1 receptor agonist listed on the Department of Human Services (Department) Statewide Preferred Drug List (PDL) will remain a compensable service for MA beneficiaries.
3. Inform providers of the addition of the GLP-1 Receptor Agonists therapeutic class to the Statewide PDL.
4. Inform providers that drugs containing a GLP-1 receptor agonist will continue to be covered for conditions other than overweight and obesity with a prior authorization.
5. Issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Obesity Treatment Agents submitted for prior authorization.

SCOPE:

*01-26-39	09-26-39	27-26-39	33-26-39
02-26-39	11-26-39	30-26-39	
03-26-39	14-26-39	31-26-39	
08-26-39	24-26-39	32-26-39	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/agencies/dhs/departments-offices/omap-info

This bulletin applies to all licensed pharmacies and prescribers enrolled in the MA Program. The guidelines to determine the medical necessity of Obesity Treatment Agents will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Obesity Treatment Agents to the appropriate managed care organization.

BACKGROUND/DISCUSSION:

GLP-1 receptor agonists are used to treat diabetes and have been covered by the MA Program since their introduction to the market in 2005. Recently, drugs containing GLP-1 receptor agonists have been approved by the U.S. Food and Drug Administration to treat overweight, obesity, obstructive sleep apnea, and noncirrhotic metabolic dysfunction-associated steatohepatitis with moderate to advanced liver fibrosis and to reduce cardiovascular risk in patients who have had a heart attack or stroke or have peripheral arterial disease.

The MA Program began covering drugs containing a GLP-1 receptor agonist to treat overweight and obesity in January 2023 for MA beneficiaries who meet the prior authorization guidelines. Coverage of drugs for weight loss is an optional benefit for Medicaid programs. See 42 U.S.C. § 1396r-8(d)(2)(A). The MA Program will discontinue coverage for drugs containing a GLP-1 receptor agonist for the treatment of overweight or obesity for MA beneficiaries.

Effective January 1, 2026, drugs containing a GLP-1 receptor agonist will not be covered for the treatment of overweight or obesity. Drugs containing a GLP-1 receptor agonist will continue to be covered for all other medically accepted indications with a prior authorization. Saxenda (liraglutide) will no longer be covered for any indication.

Obesity Treatment Agents that do not contain a GLP-1 receptor agonist will continue to be covered by the MA Program. Drugs that are designated as preferred in the Obesity Treatment Agents Statewide PDL therapeutic class will be available without prior authorization (e.g., phentermine capsule, phentermine tablet) as long as quantity limits/daily dose limits are not exceeded.

The Department is adding a new therapeutic class to the Statewide PDL titled GLP-1 Receptor Agonists. The drugs containing a GLP-1 receptor agonist that were previously included in the Hypoglycemics, Incretin Mimetics/Enhancers and Obesity Treatment Agents therapeutic classes will be moved to the new GLP-1 Receptor Agonists Statewide PDL therapeutic class. The Department is issuing updated prior authorization guidelines for the Obesity Treatment Agents class to reflect this change.

PROCEDURE:

Current prior authorizations for drugs containing a GLP-1 receptor agonist will no longer be valid after December 31, 2025, regardless of the condition being treated. Prescribers will

need to submit new requests for prior authorization for all beneficiaries receiving a drug containing a GLP-1 receptor agonist effective January 1, 2026.

Current prior authorizations for drugs designated as non-preferred in the Obesity Treatment Agents therapeutic class are not affected by these changes.

The procedures for prescribers to request prior authorization of Obesity Treatment Agents are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Obesity Treatment Agents) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements
https://www.pa.gov/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.pa.gov/agencies/dhs/resources/pharmacy-services/clinical-guidelines

I. Requirements for Prior Authorization of Obesity Treatment Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Obesity Treatment Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Obesity Treatment Agent. See the Preferred Drug List (PDL) for the list of preferred Obesity Treatment Agents at: https://papdl.com/preferred-drug-list.

2. An Obesity Treatment Agent with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.

3. A stimulant Obesity Treatment Agent when there is a record of a recent paid claim for another stimulant Obesity Treatment Agents in the point-of-sale on-line claims adjudication system (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Obesity Treatment Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a request for a drug containing a glucagon-like peptide-1 (GLP-1) receptor agonist, see the prior authorization guidelines related to GLP-1 Receptor Agonists;

   NOTE: GLP-1 Receptor Agonists are not covered for the treatment of overweight or obesity. GLP-1 Receptor Agonists are covered for the treatment of diagnoses that are indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or other medically accepted indications excluding treatment of overweight or obesity.

   OR

2. For a request for Evekeo or any other Obesity Treatment Agent containing amphetamine for any indication other than the treatment of obesity, see the prior authorization guidelines related to Stimulants and Related Agents; **OR**

3. **One** of the following:

   a. For beneficiaries 18 years of age and older, **one** of the following:

      i. Has a body mass index (BMI) greater than or equal to 30 kg/m^2

ii. **Both** of the following:

a) **One** of the following:

(i) Has a BMI greater than or equal to 27 kg/m^2 and less than 30 kg/m^2
(ii) Has been determined by the prescriber to be a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for the beneficiary's ethnicity, etc.

b) Has at least **one** weight-related comorbidity as determined by the prescriber, such as dyslipidemia, hypertension, type 2 diabetes, prediabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc.

b. For beneficiaries less than 18 years of age, has a BMI in the 95th percentile or greater standardized for age and sex based on current Centers for Disease Control and Prevention charts;

AND

4. Has been counseled about lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity); **AND**

5. Is age- and weight-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

6. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

7. Does not have a contraindication to the prescribed drug; **AND**

8. For Evekeo or any other Obesity Treatment Agent containing amphetamine, **all** of the following:

a. Was assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescribing provider,

b. Has documentation that the beneficiary has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction,

c. For a beneficiary with a history of comorbid substance dependency, abuse, or diversion, has results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances,

d. **Both** of the following:

i. Has a history of trial and failure of or a contraindication or an intolerance to all other Obesity Treatment Agents (preferred and non-preferred)
ii. Has documentation from the prescriber explaining the rationale for why the requested drug is needed and a plan for tapering;

AND

9. For all other non-preferred Obesity Treatment Agents, has history of therapeutic failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication; **AND**

10. For therapeutic duplication of a stimulant Obesity Treatment Agent, **one** of the following:

    a. Is being titrated to or tapered from another stimulant Obesity Treatment Agent
    b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

    AND

11. If a prescription for an Obesity Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR OBESITY TREATMENT AGENTS: The determination of medical necessity of a request for renewal of a prior authorization for an Obesity Treatment Agent that was previously approved will take into account whether the beneficiary:

1. **One** of the following:

    a. **One** of the following:

        i. For beneficiaries 18 years of age and older, experienced a percent reduction of baseline body weight that is consistent with the recommended cutoff in FDA-approved package labeling, peer-reviewed medical literature, or consensus treatment guidelines after three months of therapy with the maximum recommended/tolerated dose
        ii. For beneficiaries less than 18 years of age, experienced a percent reduction of baseline BMI or BMI z-score that is consistent with the recommended cutoff in FDA-approved package labeling, peer-reviewed medical literature, or consensus

treatment guidelines after three months of therapy with the maximum recommended/tolerated dose,

b. Experienced improvement in degree of adiposity or waist circumference from baseline,

c. Experienced clinical benefit from the Obesity Treatment Agent in at least **one** weight-related comorbidity from baseline as determined by the prescriber, such as dyslipidemia, hypertension, type 2 diabetes, prediabetes, cardiovascular disease, obstructive sleep apnea, metabolic syndrome, etc;

AND

2. Has been counseled about lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity); **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Does not have a contraindication to the prescribed drug; **AND**

5. For Evekeo or any other Obesity Treatment Agent containing amphetamine, **both** of the following:

   a. For a beneficiary with a history of comorbid substance dependency, abuse, or diversion, has results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances
   b. Has documentation from the prescriber explaining the rationale for why the requested drug continues to be needed and plan for tapering;

   AND

6. For all other non-preferred Obesity Treatment Agents, has history of therapeutic failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication; **AND**

7. For therapeutic duplication of a stimulant Obesity Treatment Agent, **one** of the following:

   a. Is being titrated to or tapered from another stimulant Obesity Treatment Agent
   b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

   AND

8. If a prescription for an Obesity Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into

account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Obesity Treatment Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

C. Dose and Duration of Therapy

Requests for prior authorization of Obesity Treatment Agents will be approved as follows:

1. For Evekeo or any other Obesity Treatment Agent containing amphetamine, all requests will be approved for up to three months.

2. For all other Obesity Treatment Agents:

   a. Initial requests for prior authorization will be approved for up to four months.
   b. Renewals of requests for prior authorization will be approved for up to six months.