Obesity Management Reimbursement Questions

Webinar Questions	Presenter Responses
For OSA, what are insurance companies looking at for before approving a GLP1?	Health plans look at many things when considering any reimbursement and the GLPs are no different. Generally speaking, payors want to make sure a drug is on their formulary, that the member benefits include the drug, and that the patient meets medical necessity for the medication. Other factors can be involved depending on the plan and the pharmacy benefit managers but understanding the health plan's medical necessity guidelines is a good first step.
When a peer-to-peer appeal is done with a medical director of an insurance plan, are they allowed to overturn the appeal even though a therapy is explicitly not covered in the current policy? I have been told many times that a therapy is not covered (they show me where in the policy where that is stated), and they can't approve coverage. Not sure what the point of a peer-to-peer discussion is.	Generally speaking, the answer is yes but again, there is wide discrepancy in how each health plan approaches this topic. The idea of a peer -to- peer is to exchange clinical expertise and insight from the real-world provider to the health plan's clinical representative. Between the two, the goal should be to arrive at the best outcome for the patient that takes into account medical expertise and judgement.
Any guidance on language to use for prior authorization for GLPs and clinic notes?	Be familiar with health plan guidelines for the use of these medications and which specific medication is on their formulary. Then, prepare accordingly for the prior authorization. Also, when applying for prior authorization, take note of what you are asked and what their denial rationale is, if denied. This information should help you the next time you request authorization.
How do coverage policies for anti-obesity medications differ between Medicare, Medicaid, and employer-sponsored insurance, and what impact does this have on patient access to pharmacotherapy?	Generally speaking, CMS guidelines are mimicked by commercial insurance plans. Medicaid can follow CMS as well but check with your state for their specific guidelines because the state-to-state variability can be significant for these public plans. Patient access may be limited for a variety of reasons, including strict coverage policies, but medical necessity is key.