Clinical Policy: Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists Weight Management Benefit for Pediatric Members

Reference Number: CP.PMN.305
Effective Date: 03.01.26
Last Review Date: 08.26
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following agents contain a synthetic glucagon-like peptide-1 (GLP-1) receptor agonist which may be medically necessary for chronic weight management and require prior authorization through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit: liraglutide (Saxenda®), semaglutide (Wegovy®), and tirzepatide (Zepbound®).

** These criteria do NOT apply to orforglipron (Foundayo™) due to lack of clinical data establishing safety and effectiveness of orforglipron in pediatric patients. Requests for Foundayo for adults aged 18-21 years should be reviewed using state guidance for weight management and/or other applicable policies, including but not limited to CP.PMN.16 formulary exception policy.*

FDA Approved Indication(s)

Liraglutide (Saxenda), Wegovy, and Zepbound are indicated in combination with a reduced calorie diet and increased physical activity to reduce excess body weight and maintain weight reduction long term in:

- Adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition
- Pediatric patients aged 12 years and older (with body weight greater than 60 kg for liraglutide [Saxenda]) with obesity (*liraglutide [Saxenda] and Wegovy only)*

Wegovy and Zepbound are also indicated for other uses which are not included in this policy; refer to the prescribing information of each drug for details.

Limitation(s) of use:

- Coadministration with other liraglutide-, semaglutide-, tirzepatide-containing products or with any other GLP-1 receptor agonists is not recommended.
- The safety and effectiveness of liraglutide (Saxenda) in pediatric patients with type 2 diabetes have not been established.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that GLP-1 receptor agonists for weight management for pediatric members are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Weight Management Request Through EPSDT Benefit (must meet all):*

**Benefit exclusions may not apply; evaluation for EPSDT should be based solely on medical necessity, unless the requested drug is not part of the Medicaid Drug Rebate Program (MDRP) or the state Medicaid agency allows coverage of non-MDRP drugs (see Appendix D)*

1. Member meets one of the following (a, b, or c):
   a. Body mass index (BMI) ≥ 30 kg/m^2;
   b. BMI ≥ 27 kg/m^2 with at least one indicator of increased cardiovascular risk (e.g., coronary artery/heart disease, hypertension, dyslipidemia, diabetes, elevated waist circumference) or other obesity-related medical condition (e.g., sleep apnea);
   c. If age is between 10 and 17 years: BMI ≥ 95th percentile standardized for age and sex (*see Appendix D)*;
2. Both of the following (a and b):
   a. Age ≥ 10 years;
   b. Age < 21 years or the state-specific maximum age for coverage under the EPSDT benefit, whichever is lower;
3. For members with concurrent type 2 diabetes mellitus (T2DM), both of the following (a and b):
   a. Member has received optimal diabetic standard of care therapy as evidenced by a trial of ≥ 3 consecutive months of a health plan-preferred GLP-1 receptor agonist*, unless clinically significant adverse events are experienced, all are contraindicated, or the health-plan preferred GLP-1 receptor agonist is not approved for the member's age;
      **Prior authorization may be required*
   b. If member is currently receiving a GLP-1 receptor agonist and is requesting to switch to a different GLP-1 receptor agonist, medical justification* supports necessity for the switch;
      **Intolerance due to common adverse effects of the GLP-1 receptor agonists class such as gastrointestinal symptoms is not considered acceptable medical justification*
4. Documentation supports that member has previously tried a weight loss treatment plan administered by a health care provider that involves a reduced calorie diet, increased physical activity, and behavioral modification for at least 6 months;
5. Documentation supports that member will continue to be actively engaged in a weight loss treatment plan administered by a health care provider that involves a reduced calorie diet, increased physical activity, and behavioral modification adjunct to GLP-1 receptor agonist therapy;
6. If request is for Saxenda, member must use liraglutide (generic Saxenda), unless contraindicated, clinically significant adverse effects are experienced, or brand is preferred per PDL;
7. If request is for Zepbound Pre-filled Single-Use Pen formulation, member must use Zepbound KwikPen formulation;
8. The requested agent is not prescribed concurrently with any other GLP-receptor agonists;

9. The requested agent and prescribed dose are not considered experimental or investigational for the member's diagnosis and age;
10. The requested dose is within the FDA maximum limit for any FDA-approved indication.

Approval duration: 6 months

II. Continued Therapy

A. Weight Management Request Through EPSDT Benefit (must meet all)**:**

1. Member meets one of the following (a, or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by one of the following (a or b):
   a. If this is the first renewal request, one of the following (i or ii):
      i. For liraglutide (Saxenda) requests, one of the following (1 or 2):
         1) For age ≥ 18 years: Member has lost > 4% of baseline body weight;
         2) For age < 18 years: Member has lost > 1% of baseline BMI;
      ii. For all other requests, member has lost ≥ 5% of baseline body weight (for age ≥ 18 years) or baseline BMI (for age < 18 years);
   b. If this is a second or subsequent renewal request, one of the following (i or ii):
      i. For age ≥ 18 years: Member has lost weight and/or maintained weight loss on therapy;
      ii. For age < 18 years: Member has achieved BMI reduction and/or maintained BMI on therapy;
3. If request is for Saxenda, member must use liraglutide (generic Saxenda), unless contraindicated, clinically significant adverse effects are experienced, or brand is preferred per PDL;
4. If request is for Zepbound Pre-filled Single-Use Pen formulation, member must use Zepbound KwikPen formulation;
5. The requested agent is not prescribed concurrently with any other GLP-receptor agonists;
6. Documentation supports that member is actively enrolled in a weight loss program that involves a reduced calorie diet, increased physical activity, and behavioral modification adjunct to GLP-1 receptor agonist therapy;
7. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication.

Approval duration: 12 months or to the member's 21st birthday, whichever is shorter

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BMI: body mass index
EPSDT: early and periodic screening, diagnostic and treatment
FDA: Food and Drug Administration
GLP-1: glucagon-like peptide-1
MDRP: Medicaid Drug Rebate Program
T2DM: type 2 diabetes mellitus

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of GLP-1 Receptor Agonists for T2DM		
Ozempic® (semaglutide)*	Injection: • 0.25 mg to 2 mg SC once weekly, increased no more frequently than every 4 weeks • For patients with type 2 diabetes and chronic kidney disease, the dosage should be increased to the maintenance dose of 1 mg once weekly after at least 4 weeks on the 0.5 mg dosage Tablet: Initial dose: 1.5 mg PO QD. After 30 days on the 1.5 mg dose, increase to 4 mg PO QD. May increase to 9 mg PO QD if needed after at least 30 days on the 4 mg dose	Injection: 2 mg/week Tablet: 9 mg/day
Rybelsus® (semaglutide)*	Initial dose: 3 mg PO QD. After 30 days on the 3 mg dose, increase to 7 mg PO QD. May increase to 14 mg PO QD if needed after at least 30 days on the 7 mg dose	14 mg/day
Trulicity® (dulaglutide)	0.75 mg to 1.5 mg SC once weekly May increase to 3 mg once weekly if needed after at least 4 weeks on 1.5 mg dose. May further increase to 4.5 mg once weekly if needed after at least 4 weeks on 3 mg dose	4.5 mg/week
liraglutide (Victoza®)	Initial: 0.6 mg SC QD for 7 days Maintenance: 1.2 mg to 1.8 mg SC QD	1.8 mg/day
Mounjaro® (tirzepatide)	Initial: 2.5 mg SC once weekly May increase by 2.5 mg every 4 weeks up to 10 mg (pediatrics) or 15 mg once weekly (adults)	Adult: 15 mg/week Pediatrics: 10 mg/week

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

** Ozempic and Rybelsus tablets are not substitutable on a mg per mg basis. Use either formulation, but do not use both formulations at the same time. Patients may switch between formulations after 30 days of treatment (i.e., after the initiation phase). When switching between the formulations, initiate the other formulation the day after discontinuing the previous formulation.*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2), prior hypersensitivity reaction to liraglutide, semaglutide, or tirzepatide or to any of the excipients in liraglutide (Saxenda), Wegovy, or Zepbound
- Boxed warning(s): risk of thyroid C-cell tumors

Appendix D: General Information

- BMI = 703 x [weight (lbs)/height (inches)^2].
- Examples of coronary artery/heart disease include coronary artery bypass graft, angina, and history of myocardial infarction or stroke.
- The Endocrine Society practice guideline on pharmacological management of obesity states that a weight loss < 5% after 3 months of therapy indicates the weight loss medication is ineffective. In such cases, the Endocrine Society recommends that the medication be discontinued and alternative medications be considered.
- BMI cut-offs (95th percentile) for obesity by age and sex for pediatric patients aged ≥ 12 years:

	95th Percentile BMI Value	
Age (in years)	**Male**	**Female**
10	22.1	22.9
10.5	22.6	23,5
11	23.2	24.1
11.5	23.7	24.6
12	24.2	25.2
12.5	24.7	25.7
13	25.1	26.3
13.5	25.6	26.8
14	26.0	27.2
14.5	26.4	27.7
15	26.8	28.1
15.5	27.2	28.5
16	27.5	28.9
16.5	27.9	29.3
17	28.2	29.6
17.5	28.6	30.0

- The MDRP is a program authorized by Section 1927 of the Social Security Act that helps offset the Federal and state costs of outpatient prescription drugs dispensed to Medicaid patients. To have their drugs covered under Medicaid, drug manufacturers are required to enter into 3 agreements: 1) a National Drug Rebate Agreement with the Secretary of the Department of Health and Human Services, 2) a pricing agreement for the Section 340B Drug Pricing Program administered by the Health Resources and Services

Administration, and 3) a master agreement with the Secretary of Veterans Affairs for the Federal Supply Schedule. A drug and its intended use may be considered medically necessary and approvable under EPSDT while being an excluded use under the member's plan as long as it is part of the MDRP, unless the state Medicaid agency directs otherwise:

State: Plan* **Note: Not all plans below may be utilizing this policy*	**Does the state Medicaid agency allow coverage of drugs under EPSDT for drugs not on the MDRP?**	**Policy applicability as of June 2026, regardless of MDRP status**
AZ: AZCH	No, unless the diagnosis is a covered benefit (not an exclusion) AND no other treatment options apply	No, use GL-356248 GLP-1 Agonists - AZM
AR: Arkansas	No	No, CP.PMN.53 if off-label
CA: CAHW/HNCA	Carve out for Pharmacy Benefit; Yes for Medical Pharmacy	Not applicable
DE: DE 1st	Yes	No, use DE.PMN.50
FL: SSHP	No	No, use CP.PMN.234
GA: PSHP	Yes	Yes
HI: Ohana	Yes	Yes
IA: ITC	No	Not applicable
IL: Meridian IL	Yes	No, use MDN.CP.PMN.305
IL: Youthcare	Yes	No, use IL.PMN.305
IN: MHS IN	Yes	No (send to plan)
KS: Sunflower	No	Not applicable
KY: Wellcare of KY	Carve out for Pharmacy Benefit; For Medical Benefit: No	Not applicable
LA: LHCC	No	No, use State PDL criteria
MI: Meridian MI	Yes	No, use State PDL criteria
MO: Home State	Not applicable (i.e., Full Medicaid pharmacy benefit carve-out)	Not applicable
MS: Magnolia	Carve out for Pharmacy Benefit; Yes for Medical Pharmacy	Not applicable
NC: CCH	Yes	No, use State PDL criteria
NE: NTC	No	No, use State PDL criteria
NH: NHHF	Yes	Yes
NJ: Fidelis	Yes	Yes
NV: NVSS	Yes	No, use MSM 1200 -1- KK. Incretin Mimetics
NY: Fidelis (Medicaid)	Carve out for Pharmacy Benefit; For Medical Benefit: No, unless the diagnosis is a covered benefit (not an exclusion) AND no other treatment options apply	Not applicable

State: Plan* *Note: Not all plans below may be utilizing this policy	Does the state Medicaid agency allow coverage of drugs under EPSDT for drugs not on the MDRP?	Policy applicability as of June 2026, regardless of MDRP status
NY: Fidelis (CHIP, Essential)	Not applicable	Not applicable
OH: Buckeye	Carve out for Pharmacy Benefit; Yes for Medical Pharmacy	Not applicable
OK: Oklahoma Complete Health	Yes	No, use State PDL criteria
OR: Trillium	Yes	No, use OR.CP.PMN.1015
PA: PAHW (Medicaid, CHIP)	Not applicable	Not applicable
SC: ATC	Yes, and no redirection to PDL agents allowed	No, use SC.CP.PMN.305
TX: Superior	No	Not applicable
WA: CCWA	Yes, but must document medical justification	No (carved out drug)
WI: MHS	Not applicable (i.e., Full Medicaid pharmacy benefit carve-out)	Not applicable

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Liraglutide (Saxenda)	**Dose escalation schedule**: • Week 1: 0.6 mg SC QD • Week 2: 1.2 mg SC QD • Week 3: 1.8 mg SC QD • Week 4: 2.4 mg SC QD • Week 5 and onward: 3 mg SC QD **Adult patients**: If patients do not tolerate an increased dose during dose escalation, consider delaying dose escalation for approximately one additional week. Discontinue liraglutide (Saxenda) if the patient cannot tolerate the 3 mg dose. **Pediatric patients**: Dose escalation for pediatric patients may take up to 8 weeks. Pediatric patients who do not tolerate 3 mg daily may have their dose reduced to 2.4 mg daily. Discontinue liraglutide (Saxenda) if the patient cannot tolerate the 2.4 mg dose.	3 mg/day
Semaglutide (Wegovy) injection	**Adults and pediatric patients aged ≥ 12 years old**: SC once weekly following dose escalation schedule: • Week 1 through 4: 0.25 mg	Adults: 7.2 mg/week

Drug Name	Dosing Regimen	Maximum Dose
	• Week 5 through 8: 0.5 mg • Week 9 through 12: 1 mg • Week 13 through 16: 1.7 mg • Week 17 and onward*: 1.7 mg or 2.4 mg If patients do not tolerate a dose during dose escalation, consider delaying dose escalation for 4 weeks. The maintenance dosage is either 2.4 mg (recommended) or 1.7 mg once weekly. For adult patients who tolerate the 2.4 mg dosage for at least 4 weeks and additional weight reduction is clinically indicated, the dosage may be increased to a maximum dosage of 7.2 mg once weekly. ** 0.25 mg. 0.5 mg, and 1 mg once-weekly dosages are initiation and escalation dosages and are not approved as maintenance dosages*	Pediatrics: 2.4 mg/week
Semaglutide (Wegovy) tablets	**Adults:** PO once weekly following dose escalation schedule: • Days 1 through 30: 1.5 mg • Days 31 through 60: 4 mg • Days 61 through 90: 9 mg • Days 91 and onward: 25 mg The recommended maintenance dosage is 25 mg daily. If patients do not tolerate the 25 mg once daily maintenance dosage, consider switching to Wegovy injection 1.7 mg once weekly.	25 mg/day
Tirzepatide (Zepbound)	**Adults**: The recommended starting dosage is 2.5 mg SC once weekly for 4 weeks and increased by 2.5 mg every 4 weeks until the maximum tolerated recommended maintenance dosage is achieved. Recommended maintenance dosage: 5 mg, 10 mg, or 15 mg SC once weekly	15 mg/week

VI. Product Availability

Drug Name	Availability
Liraglutide (Saxenda)	• Pre-filled, multi-dose pens: 0.6 mg, 1.2 mg, 1.8 mg, 2.4 mg, 3 mg (6 mg/mL, 3 mL)
Semaglutide (Wegovy)	• Prefilled, single-dose pens: 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg, Wegovy HD 7.2 mg

Drug Name	Availability
	• Prefilled, single-dose syringes: 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg • Tablets: 1.5 mg, 4 mg, 9 mg, 25 mg
Tirzepatide (Zepbound)	• Pre-filled, single-dose pens: 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg • Pre-filled, single-dose vials: 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg • Multi-dose vials: 10 mg/2.4 mL (4.17 mg/mL) for four 2.5 mg/0.6 mL doses, 20 mg/2.4 mL (8.33 mg/mL) for four 5 mg/0.6 mL doses, 30 mg/2.4 mL (12.5 mg/mL) for four 7.5 mg/0.6 mL doses, 40 mg/2.4 mL (16.7 mg/mL) for four 10 mg/0.6 mL doses, 50 mg/2.4 mL (20.8 mg/mL) for four 12.5 mg/0.6 mL doses, 60 mg/2.4 mL (25 mg/mL) for four 15 mg/0.6 mL doses • Single-patient-use KwikPens: 10 mg/2.4 mL (4.17 mg/mL) for four 2.5 mg/0.6 mL doses, 20 mg/2.4 mL (8.33 mg/mL) for four 5 mg/0.6 mL doses, 30 mg/2.4 mL (12.5 mg/mL) for four 7.5 mg/0.6 mL doses, 40 mg/2.4 mL (16.7 mg/mL) for four 10 mg/0.6 mL doses, 50 mg/2.4 mL (20.8 mg/mL) for four 12.5 mg/0.6 mL doses, 60 mg/2.4 mL (25 mg/mL) for four 15 mg/0.6 mL doses

VII. References

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created. Added new formulation Wegovy tablets to policy; revised age limit to ≥ 10 years (previously ≥ 12 years); for second or subsequent renewal requests in continued therapy, clarified criteria for age ≥ 18 years and added criteria for age < 18 years, "Member has achieved BMI reduction and/or maintained BMI on therapy"; updated continued therapy approval duration from 6 months to 12 months or to the member's 21st birthday, whichever is shorter. RT4: for Zepbound, added new multi-dose vial dosage form and new KwikPen dosage form. Added note to include information about benefit exclusions and MDRP, including state Medicaid agency directions to Appendix D based on confirmed responses from each health plan.	02.16.26	02.26
2Q 2026 annual review: no significant changes; updated MDRP table in Appendix D with IL-specific policies to use for IL Meridian and Youthcare Medicaid per health plan request; references reviewed and updated. RT4: added new Wegovy HD injection 7.2 mg formulation; updated MDRP table in Appendix D for TX Superior policy applicability to "No" per health plan request; added disclaimer regarding policy applicability for orforglipron (Foundayo). Updated Appendix D.	05.05.26	05.26
RT4: added new formulation Wegovy prefilled syringe to policy.	05.20.26	
Per June SDC: for initial approval criteria and continued therapy, added if request is for Zepbound Pre-filled Single-Use Pen formulation, member must use Zepbound KwikPen formulation.	06.09.26	08.26
Updated MDRP table in Appendix D to use SC-specific policies for SC ATC per health plan request.	08.12.26	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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