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

Reference Number: MDN.CP.PMN.305
Effective Date: 03.01.26
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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®).

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]) (*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)**:**

1. Weight loss is a benefit exclusion and is not a covered benefit.

II. Continued Therapy

A. Weight Management Request Through EPSDT Benefit (must meet all)**:**
1. Not eligible for continued therapy.

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
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)	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	2 mg/week
Rybelsus® (semaglutide)	Formulation R1:* 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 Formulation R2:* 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 **Formulations R1 and R2 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*	Formulation R1: 14 mg/day Formulation R2: 9 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	4.5 mg/week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	further increase to 4.5 mg once weekly if needed after at least 4 weeks on 3 mg dose	
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 15 mg once weekly	15 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.

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**
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

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)	**Adults and pediatric patients aged ≥ 12 years old**: SC once weekly following dose escalation schedule: • Week 1 through 4: 0.25 mg • 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. ** 0.25 mg. 0.5 mg, and 1 mg once-weekly dosages are initiation and escalation dosages and are not approved as maintenance dosages*	2.4 mg/week
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.	15 mg/week

Drug Name	Dosing Regimen	Maximum Dose
	Recommended maintenance dosage: 5 mg, 10 mg, or 15 mg SC once weekly	

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)	• Pre-filled, single-dose pens: 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 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

VII. References

1. Social Security Act, Section 1905. Available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm. Accessed January 29, 2025.
2. EPSDT Coverage Guide. Published June 2014. Available at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf. Accessed January 28, 2025.
3. Saxenda Prescribing Information. Plainsboro, NJ: Novo Nordisk Inc.; May 2025. Available at: www.saxenda.com. Accessed December 16, 2025.
4. Wegovy Prescribing Information. Plainsboro, NJ: Novo Nordisk Inc.; August 2025. Available at: www.wegovy.com. Accessed December 16, 2025.
5. Zepbound Prescribing Information. Indianapolis, IN: Lilly USA, LLC; December 2024. Available at: https://uspl.lilly.com/zepbound/zepbound.html#pi. Accessed December 16, 2025.
6. Apovian CM, Aronne LJ, Bessesen DH, et al. Pharmacological management of obesity: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2015; 100(2): 42-362.
7. Styne, DM, Arslanian SA, Connor EL, et al. Pediatric obesity - assessment, treatment, and prevention: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. March 017; 102(3):709-757.
8. Hampl SE, Hassink SG, Skinner AC, et al. Clinical practice guideline for the evaluation and treatment of children and adolescents with obesity [published online ahead of print, 2023 Jan 9]. Pediatrics. 2023;e2022060640

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created from CP.PMN.xx to adapt to HFS PDL	1.26.25	

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.

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.