

Clinical Policy: Lorcaserin (Belviq)  
Reference Number: HIM.PA.110  
Effective Date: 05/17  
Last Review Date:  
Line of Business: Health Insurance Marketplace

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Lorcaserin (Belviq®) is a serotonin 2C receptor agonist.

### FDA approved indication

Belviq is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of:

- 30 kg/m<sup>2</sup> or greater (obese) or
- 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes)

Limitations of use: The safety and efficacy of coadministration with other products for weight loss have not been established. The effect of Belviq on cardiovascular morbidity and mortality has not been established.

### Policy/Criteria

Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

## I. Initial Approval Criteria

### A. Weight Management (must meet all):

1. Member meets one of the following (a or b):
  - a. BMI  $\geq$  30 kg/m<sup>2</sup>;
  - b. BMI  $\geq$  27 kg/m<sup>2</sup> with at least one indicator of increased cardiovascular risk (e.g., hypertension, dyslipidemia, diabetes, elevated waist circumference) or other obesity-related medical condition (e.g., sleep apnea);
2. Age  $\geq$  18;
3. Failure of phentermine or phendimetrazine at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced; *\*Note: phentermine and phendimetrazine require prior authorization.*
4. Dose does not exceed 20 mg/day (2 tablets per day).

**Approval duration: 12 weeks**

### B. Other diagnoses/indications

1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

## II. Continued Therapy

### A. Weight Management (must meet all):

**Lorcaserin**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. BMI  $\geq 25$  kg/m<sup>2</sup>;
3. Member meets one of the following (a or b):
  - a. If this is the first renewal request, documentation that member has lost  $\geq 5\%$  of baseline body weight;
  - b. If this is a second or subsequent renewal request, documentation that member has lost weight and/or maintained weight loss on therapy;
4. If request is for a dose increase, new dose does not exceed 20 mg per day (2 tablets per day).

**Approval duration: 12 weeks**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**Approval duration: 12 weeks**

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

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 or evidence of coverage documents

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

BMI: body mass index

FDA: Food and Drug Administration

**V. References**

1. Belviq Prescribing Information. Woodcliff Lake, NJ: Eisai Inc.; November 2016. Available at: <https://www.belviq.com/>. Accessed January 20, 2017.
2. Jensen MD, Ryan DH, Apovian CM, Ard JD, Comuzzie AG, Donato KA, Hu FB, Hubbard VS, Jakicic JM, Kushner RF, Loria CM, Millen BE, Nonas CA, Pi-Sunyer FX, Stevens J, Stevens VJ, Wadden TA, Wolfe BM, Yanovski SZ. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation*. 2014;129(suppl 2):S102–S138.

| Reviews, Revisions, and Approvals | Date  | P&T Approval Date |
|-----------------------------------|-------|-------------------|
| Policy created                    | 01/17 |                   |

**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.

## CLINICAL POLICY

### Lorcaserin



**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.

©2017 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.